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Gender and experience-level differences among family systems therapists as measured in six skill categories.

Serena Lurie Bloomfield
University of Massachusetts Amherst

GENDER AND EXPERIENCE-LEVEL DIFFERENCES AMONG FAMILY SYSTEMS THERAPISTS AS MEASURED IN SIX SKILL CATEGORIES

A Dissertation Presented

By

SERENA LURIE BLOOMFIELD

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Approved as to style and content by:

Dr. Sheryl Reichmann-Hruska,
Chairperson of Committee

Dr. Janine Roberts, Member

Dr. Stuart Golann, Member

Mario D. Fantini, Dean
School of Education

DEDICATION

To my FATHER who told me I could do anything;

To my MOTHER who encouraged and accepted me; and

To my HUSBAND who has consistently allowed me my idiosyncracies in carrying out my quests.

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ABSTRACT

Gender and Experience-Level Differences Among
Family Systems Therapists as Measured
in Six Skill Categories

(May 1985)

Serena Lurie Bloomfield, B.A., Smith College
M.Ed., Ed.D., University of Massachusetts
Directed by: Professor Sheryl Reichmann-Hruska

This research was designed to determine gender and experience-level differences among family systems therapists who identified themselves as using one of the following models: structural, strategic, or Milan-style systemic. The six skill areas studied were: 1) perceptual/conceptual skills, especially as used in assessment; 2) therapist attention to forming a relationship with the family; 3) attention to the task-related aspects of therapy; 4) therapist use of direct interventions; 5) therapist use of indirect interventions; and 6) therapist directiveness.

Twenty-nine family therapists (18 female, 11 male) from community-based mental health centers participated. Experience level was divided into three categories: fewer than two years, two to three years, and more than three

years. Respondents completed a written questionnaire containing a case vignette, questions tapping the six skills, and additional questions relating to therapists' self-perception and supervisor and family perception of them.

Respondents rated themselves on scales for each skill, and gave rationales for their ratings. Examples of interventions in response to the case vignette were coded by raters.

Data was analyzed both quantitatively and qualitatively. Interrater reliability was high (.81 using Pearson's product-moment coefficient). The most useful results were qualitative reflecting tone, style, and approach to the case.

Major differences were found for experience level; but only slight gender differences were found. With decreased experience, responses decreased in complexity, specificity and integration of theory with interventions. The most experienced gave answers which integrated theory and action. Men and women were rated as different in use of perceptual/conceptual skills and approach to the case. The middle group was reliant on theory but gave little sense of action or what interventions they would use. The least experienced group gave choppy answers with little understanding of theory or intervention.

Results have several implications. The progression of skill acquisition and the importance of style integrated with theory can guide trainers and student expectations. The existence of sex-role stereotypic behaviors in family therapists which the literature suggests was challenged.

TABLE OF CONTENTS

DEDICATION iv

ACKNOWLEDGEMENTS v

ABSTRACT vii

LIST OF TABLES xiii

Chapter
I. INTRODUCTION 1

Organization of the Chapter 1
Background of the Study 1
Purpose of the Study 6
Significance of the Study 7
Statement of Limitations 8
Definition of Terms 10
Outline of Following Chapters 12

II. REVIEW OF THE LITERATURE 13

Organization of the Chapter 13
Women Psychotherapists 13
Historical perspective of women mental health professionals 14
Present career status and demographics of women mental health professionals 18
Personality characteristics of female psychotherapists 24
Male and female therapists and the therapeutic process 29
Individual therapy 30
Family therapy 41
Personal perspectives 41
Empirical research 42
Summary 44
Training and supervision of male vs. female therapists 45
Summary 51
Conclusions and implications 52
Structural, Strategic, and Systemic Family Therapy 55
Minuchin and Structural Family Therapy . . 55

The Brief Therapy Project of the Mental Research Institute (MRI) and the Interactional View: Strategic Therapy or Brief Therapy 60
Jay Haley and Cloe Madanes: Problem-solving or Strategic Therapy; Therapy for Disturbed Young People 63
The Milan Group: Long "Brief" Therapy; Strategic or Family Systems Therapy 66
Summary 69
Family Therapy Process: Microskills of the Therapist 70
Summary 76
Female Family Systems Therapists 77
Summary 82
Synthesis 82

III. METHODOLOGY 84

Organization of the Chapter 84
Design 84
Rationale for categories to be tested . . 84
Hypotheses 92
Sample 93
Instrumentation 97
Use of a written questionnaire 97
Structure of the questionnaire 98
Part I: The case vignette 98
Part II: Further questions 99
Part III: Demographics 100
Procedure 100
Pilot study 100
Final study 101
Analysis of Data 102
Development of a rating system 102
Part I 103
Part II 106
Part III 107
Interrater reliability 107
Summary 108

IV. RESULTS AND DISCUSSION 109

Organization of the Chapter 109
Results and Discussion 110
The sample 110
Age 115
Degree 115

Family therapy training 115
General clinical experience 117
Theory base 117
Discussion of demographics 118
Hypothesis 1: Statistical findings . . . 120
Qualitative findings 121
Summary and discussion 126
Hypothesis 2: Rating scale 129
Other statistical findings 132
Qualitative findings 132
Summary and discussion 136
Hypothesis 3: Rating scale 138
Other statistical findings 140
Qualitative findings 140
Summary and discussion 142
Hypothesis 4: Rating scale 144
Other statistical findings 145
Qualitative findings 146
Summary and discussion 148
Hypothesis 5: Rating scale 150
Discussion 150
Additional research findings 152
Question 6 152
Summary and discussion 155
Questions 7 and 8 155
Questions 9 and 10 157
Other findings 158
Integration of results 159

V. CONCLUSIONS AND IMPLICATIONS 163

Organization of the Chapter 163
Summary of Major Findings 163
Implications for Training 167
Research Concerns 169
Future Research 171
Summary and Conclusions 173

. . . . . .

BIBLIOGRAPHY 175

Appendix
A. LETTERS TO AGENCIES 186
B. QUESTIONNAIRE 189
C. LETTER TO SUBJECTS 205
D. RATERS' SCORING SHEET 207

LIST OF TABLES

1. Distribution of Experience by Gender 96
2. Age 111
3. Highest Degree Attained 112
4. Location of Family Therapy Training 113
5. Length of General Clinical Practice 114
6. Theory Base Preference 116
7. Self-Ratings on Task-Relationship Scale . . . 131
8. Indirect-Direct Interventions 139
9. Competency Ratings 151

CHAPTER I

INTRODUCTION

Organization of the Chapter

In this chapter a rationale is developed for research on the differences between women and men as family systems therapists. The rationale is drawn from the literature which specifically focuses on the practice of female therapists. The topic is introduced by a brief discussion of some general issues of women in therapy, then narrows to women practicing as therapists. The major articles that address the issue of women as family systems therapists are highlighted. The purpose of the study, including its limitations, is outlined. Certain terms which are specific to the research are defined.

Background of the Study

In the last fifteen years women as mental health patients or clients have been a major focus of discussion in the literature. One of the landmark pieces of research was that of Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) which found that for a sample of therapists the perceptions of the characteristics of a healthy male and a healthy female were different and that the characteristics of a healthy person which the subjects chose were the same as those chosen to represent a healthy male.

Since that study, feminist perspectives on and approaches to therapy have grown, and the role of women and the psychology of women have been redefined. Chessler (1972), for example, documented the diagnosis and treatment of women psychiatric patients. Miller (1976) developed a new theory on the needs and attributes of a psychologically healthy woman, including the need for affiliation and self-determination.

A more narrow focus on the experiences of women psychotherapists has sprung up as a specialty area in the literature. These writings have looked at women psychotherapists and psychologists from many perspectives, including: the history of women in the field of psychology and social work; the demographic and personality variables of these women; and how they compare to men as clinicians in the therapeutic process.

Overall, the literature underscores that women have played important roles in the development of the fields of psychology and psychotherapy. Unfortunately, some of their contributions have been lost for a variety of reasons. These may include loss of their names in citations due to secondary authorship or use of initials in citations, a practice which may leave readers assuming male authorship (Russo & O'Connell, 1980).

The context within which these women practice at the present, the academic settings, the public mental

health settings, and other institutions, reflect the sexist society within which we live. These settings are usually headed by men, while women make up the majority of clerical and direct care staff (Russo & VandenBos, 1981). In universities men have a greater chance of being hired than do women (Astin, 1972).

Given that women psychotherapists and psychologists work in male-dominated settings it is interesting to see what these women are like. Bachtold and Werner have carried out two major studies (1970, 1971) on the personality characteristics of female PhD psychologists. They found that overall these women do not have those assumed stereotypic characteristics found in the Broverman study (Broverman et al., 1970) but tend to be independent, self-sufficient, and dominant (Bachtold & Werner, 1970).

The youngest generation studied by Bachtold and Werner had a mean age of 38. This is significant when looking at studies on women therapists and the therapeutic process. Many of the studies which have been done and which are cited in this proposal were done using inexperienced therapists still in training and probably no older than 30.

Research on women therapists in the therapeutic process often compares women and men, although sometimes this comparison is implied in a discussion of the behavior of female therapists. There is also an assumption, stated

or implied, that the research is on individual therapy. Often certain variables such as empathy (Persely, 1975) or commitment (Swenson, 1971) are studied without enough attention to the overall process or the total range of variables which may occur even in one session (Strupp, 1977). There is also a lack of research on group or family approaches.

Within the realm of family therapy, however, research is growing including research on those therapies based on family systems theory. Much of the research is either outcome studies or case studies of certain client populations or diagnoses (Gurman & Kniskern, 1978). Very little attention is given the family therapist him or herself, and only a few articles denote differences or issues for women and men practicing in this field (Caust, Libow, & Raskin, 1981; Hare-Mustin, 1978). These articles merely present ideas which may be grounded in theory but have not been tested through research.

Caust et al. (1981) point out the new demands the fields of structural, strategic and systemic family therapies place on women. Many of the interventions and the overall means of working demand that the family therapist take an active, leadership role. She or he must manage a number of people and issues in the room at one time in a flexible manner, either giving directives or perhaps choosing to take a quieter role as dictated by the therapy.

She or he must manage the boundaries of the therapy, e.g., when people come in or who comes in, as well as manage the boundaries within the family, for example, who talks to whom and in what order.

These issues of managing boundaries and asserting personal authority were also addressed by Sheely and Anderson (1982). Speaking from their own experience in using family systems theory, they stress the necessity of a woman family therapist's being able to move from a directive, one-up position to a less directive one-down position (Fisch, 1982), or vice versa in order to help the family change. The key for them is the therapist's being able to perform a wide range of interventions despite sex-role stereotyping which might lead a family or supervisor to expect, for example, that a woman have a one-down, passive, manipulative style in all cases. The authors assert that flexibility of behavior is required which includes using personal authority or the ability to take control in the room, even while using a variety of therapeutic tools.

Reid (1983), Tollers (1983) and McDaniel (1983) also discuss issues for female family systems therapists, especially the trainee. In their different papers they note the difficulty which they have seen women have in taking control of the session in an active, directive manner. McDaniel (1983) discusses the special attention super-

visors of women trainees must give to help the women develop conceptual and instrumental executive skills.

Purpose of the Study

Unfortunately the literature on female structural/strategic family systems therapists has not been drawn from empirical research. Instead, the authors of the various works have based their conclusions on personal experience or a synthesis of a wide range of literature. Also there are many assumptions, stated or implied. One very subtle assumption is that men, even novices, naturally have the appropriate behaviors for being family systems therapists (Caust et al., 1981). Another somewhat opposite assumption is that men may have trouble using a wide range of behaviors because of sex-role stereotyping, and yet, this issue is not explicitly addressed at all. There is an implication in several of the articles (Caust et al., 1981; Sheely & Anderson, 1982) that women of all experience levels have the specific sex-role problems mentioned. Also, there is no recognition of the research on the characteristics of women psychologists which found them to have many more masculine qualities than the general population of women (Bachtold & Weiner, 1970, 1971).

Given the above issues and assumptions, the purpose of this research was twofold. It was done to deter-

mine if there were any gender differences among family systems therapists and also if there were any differences among three levels of experience. Other variables such as highest degree attained and place of training were also included in order to better tease out where differences could be attributed to gender alone, some other variable, or a combination of variables.

Significance of the Study

This research was significant because of the necessity to test the assumptions about male and female therapists being made in the literature, as mentioned above. These assumptions needed to be tested because they may have profound effects on the expectations of supervisors, teachers, and trainees themselves, and therefore on the way trainees are supervised and taught and the way they learn. The assumptions previously outlined can be limiting to the training of new therapists, supervision of therapists, and the therapy itself. It can also limit a new therapist's view of how she or he may expect to change over time.

The results of this study can be instrumental in developing a teaching and supervisory approach which meets the needs of all students, male and female, who may be at many levels of experience. Students can gain an understanding of the process of learning family therapy and can

anticipate the growth process throughout their years of practice.

Statement of Limitations

Structural, strategic, and systemic family therapy theory highlights the idea that behavior does not happen in isolation but occurs through continuous feedback loops. Behavior takes on meaning only within the context of the relationship. In this study the use of a written questionnaire limits the context within which therapists' behaviors could be viewed.

The questionnaire used to gather data in the study asked the therapist to speculate about her or his behavior in response to a given written situation. This method gave important information to the field concerning the way therapists conceptualize cases and perceive their own behavior. However, more complex and objective information which might be obtained by having subjects view live cases or a variety of situations was sacrificed.

Family therapy theory also states that each person has his or her own point of view about a relationship and his or her role in it. This way of viewing a relationship is called punctuation. This survey asked the therapist to punctuate the therapeutic interaction from his or her point of view. The questionnaire could measure only what the subjects perceived from a written case, not what

family members would have seen, what an independent rater may have seen, or what the therapist would have seen in an actual session. This is important to bear in mind when reading interpretations and generalizations made from sample data in the discussion.

The sample size was relatively small, 29 subjects. Forty subjects were desired but overloaded schedules, which was common to the research population, combined with the length and difficulty of the questionnaire, kept response rate very low. With 29 subjects some statistical manipulations could be made but other comparisons which might have added to broader generalizations were not possible.

Respondent self-selection in terms of who agrees to participate is always an important factor in survey research. One will never know what those who refused to answer would have said. Reasons for refusal or participation were not always known.

The locus of subjects, as well as the specific theoretical focus, were other factors which may have limited the generalizability of findings. Therapists were only structural/strategic or systemic therapists, so results applied only to that group. Participants were drawn from community-based mental health centers in Massachusetts, potentially eliminating those practicing in training centers, universities, or privately. However,

use of this sample group ensured a broad training and practice base.

Definition of Terms

To ensure a common understanding of terms used, definitions are provided here:

A directive therapist is a therapist who takes active charge of the session in order to produce change. This therapist may use direct or indirect interventions but is the leader of the therapeutic system. He or she is in charage of such things as asking questions, making hypotheses, developing plans, and giving tasks, rather than letting the client lead the session.

Directives are directions, for example, when a therapist gives the family a task in a therapy session.

Executive skills are the behaviors the family therapist uses in the session to "execute" or carry out the interventions.

Gender is used interchangeably with the word "sex." It refers to the differentiation of people by whether they are male or female.

Perceptual/conceptual skills as used in family therapy are those skills used to make accurate observations and explain what is seen using theoretical material. The theoretical material may include actual formal theory, specific concepts, or the application of "previous learn-

ing to the specific therapeutic situation" (Tomm & Wright, 1981, p. 230).

Sex-role stereotypes are the behavioral and attitudinal characteristics commonly ascribed to women or commonly ascribed to men as a result of traditional social expectations.

Strategic family therapy is planful therapy which views problems in terms of General Systems Theory and is highly influenced by the works of Gregory Bateson (1979). Understanding family roles and recurring patterns of interaction are essential in developing interventions which modify those patterns. There are several models of strategic therapy, two of which are discussed in the literature review.

Structural family therapy is based on the work of Salvador Minuchin (1974) who defined families in terms of their structure: subsystems, internal and external boundaries, patterns of interactions across boundaries. The executive skills involved in this therapy are thought of as active, instrumental, and quite directive.

Systemic family therapy is the method developed by Mara Selvini Palazzoli and her colleagues at the Institute for Family Study in Milan. Like the above theories, it too is based on General Systems Theory and also the communication theory of Bateson (1979). The family is viewed in terms of its rules and patterns of

interaction. The therapist leads the session using indirect methods such as circular questioning to discover the rules, formulate hypotheses about the rules, and make interventions (Selvini Palazzoli, Boscolo, Cecchin & Prata, 1978, 1980).

Summary

In this chapter a rationale for the research on family systems therapists was developed. This rationale was drawn from literature on women who are practicing psychotherapists, and more narrowly on women who are family systems therapists.

Many assumptions within the literature were discussed and from them the purpose of the study was drawn. The implications of the findings for training from the viewpoint of both the supervisor and the student were discussed. The limits of the study as well as definitions of terms used were given.

C H A P T E R I I

REVIEW OF THE LITERATURE

Organization of the Chapter

This chapter is divided into four distinct parts: 1) women as psychotherapists, which reviewed the literature on many aspects of these womens' lives including their personalities, career status, and variables, such as experience, which affect behavior in the therapy room; 2) a review of structural, strategic, and systemic family therapy theory from the perspective of the role of the therapist in executing these therapies; 3) a section outlining the microskills or behaviors used by these family therapists; and 4) current discussions concerning women family therapists' use of these and other skills. The intention of this chapter was to provide the context for the research as well as give an overview of relevant literature.

Women Psychotherapists

Because there has been little written on the topic of women family systems therapists it was necessary to broaden the literature review to include women psychologists and psychotherapists in general. In doing this, an historical perspective is included which sets the stage for women practicing family therapy at this time. This

review also documents the context within which women are practicing and the characteristics of these women. There is a section on men and women therapists and the therapeutic process and on supervision. Although the majority of this research was conducted on individual psychotherapy it can be helpful to review the kinds of research being done on the therapist's role in the therapeutic process in order to provide a perspective on the research which was proposed here.

Historical perspective of women mental health professionals

This section highlighted several social factors which have hindered female mental health workers' movement in their field. A very brief chronology of women's recognition and roles was presented to give an idea of women's experience during the past 100 years.

Women have traditionally been blocked from attaining recognition for their contributions to psychology. This is not surprising in a culture which tends to recognize and reward men more often than women. However, women have been quite active in the fields of psychology and social work, developing theory, performing research, and creating new ways of practice out in the field.

Russo and O'Connell in their research on psychology's foremothers (1980) projected several reasons for the non-recognition of women in the field. One reason was

that often women are secondary authors or researchers and their names are listed last or are not noted at all. (Even now the practice of using initials rather than names in bibliographies masks the number of women authors.) Even when women are recognized as adding worthy material to the field, the organizations which hire and promote have traditionally been top-heavy with men.

Marriage was reported as a hindrance to women and a boon to men who wish to be successful. Women's roles as mother and nurturer have not left them as much time as men have had for concentration on work, whereas marriage has allowed men more freedom to pursue their work because the family needs for nurturance and caretaking are typically being met by the women. One way, however, women may have profited by marriage was by becoming co-authors with their husbands who may have already been well-known (Russo & O'Connell, 1980).

The child guidance and other human reform movements at the end of the nineteenth century were recognized by Russo and O'Connell (1980) as the major beginning of women's massive involvement in psychology and human service work. Here the natural nurturing roles of women found an accepted place out of the home. It was women who turned what was largely volunteer work into a profession, low paid as it was.

Broderick and Schrader (1981), who wrote on the history of marriage and family therapy, noted two women who were early organizers in the movement to professionalize social work, Zilpha D. Smith and Mary Richmond. Smith stressed the importance of the family of the client, while Richmond organized the social work profession at a national level and also emphasized family work. There were other women who have made important contributions. Dorothea Dix was working at the same time to bring reform to the mental institutions. Jane Adams, a relatively better known foremother, founded Hull House, one of the first settlement houses in Chicago for young needy girls (Russo & O'Connell, 1980).

Moving into the twentieth century, World War I presented an opportunity for women to become more noticed. At that time the mental tests administered to the service men showed the need for better methods of education and testing. Many women stand out as contributing in this area (Russo & O'Connell, 1980), one example being Florence Goodenough who developed the Draw-a-Man Test. Women also became more involved in issues of child development and experimental psychology. By the 1930s Freudian psychology had found its place in our society and several women took the risk to challenge some of his ideas. One was Freida Fromm-Reichmann who redefined the Oedipal complex (Russo & O'Connell, 1980).

As of 1938, 36% of the charter members of APA (the American Psychological Association) were women (Kronk, 1979a). They contributed to the advancement of clinical psychology which, when that field began, "was first associated with 'psycho-educational' clinics where 60% of the staff psychologists positions were held by women" (Kronk, 1979a, p. 325). In the area of research women held only 10% of the positions and 11% of administrative positions. In the field of social work at this time, there were more women than men. However the imbalance of women social workers in relation to male administrators was becoming apparent (Walton, 1975).

Kronk (1979b) saw World War II as a boon to women psychologists but Russo and O'Connell (1980) disagreed. Russo and O'Connell did not deny that women played an important role but noted that, "Of the 1,006 psychologists entering the armed forces, only thirty-three were women" (p. 43). Kronk cited areas to which women made contributions: research on children and the effects of war; child care programs for children who may need to be cared for in groups if the US mainland were attacked; and testing which could screen out unfit draft inductees.

After World War II the Veterans Administration (VA) developed positions at all levels for pyschologists and counselors. At that time women were encouraged to move back home to make room for men. Women who stayed in

the profession found themselves losing promotions and positions to their male colleagues, who may have been less experienced. Norma Grieve (1975), an Australian psychologist, spoke from her own experience when she said women had to work one and one-half times as hard as men. "We tried to arrange having children so that it could fit in with the academic year and became highly mobile breast feeders--maternity leave seemed an outrageous demand" (p. 299). At that time the female academicians stayed with their jobs. Women on the front line of direct service tended to leave their jobs after marriage (Walton, 1975).

Present career status and demographics of women mental health professionals

What happened between the 1960s and the present? Most of the research on present career status and demographics was done on women in academic positions or on women psychologists in other kinds of positions. This part of the review covers the history from 1960 to the present. Research on the external or cultural barriers to women who wished to move into male-dominated areas of the field are addressed.

Astin (1972) researched women psychologists between 1960 and 1970. She found that there were fewer jobs by 1970 but more PhDs on the job market. It was women who suffered: the number of new doctorates in psychology

who signed contracts after graduation decreased by 8% for women from 69% in 1960 to 61% in 1970. For males there was only a 1% decrease from 80% to 79%. In that decade "men psychologists increased their representation almost entirely in academic employment, whereas women increased theirs less so in academe and more so in industry, business, and government" (Astin, 1972, p. 373). Regardless of this move to industry, business, and government, by 1978 women were least represented in these three areas (Russo et al., 1981).

Astin (1972) made other points regarding the distribution of men and women in universities in 1970. Of the Ph.D. psychologists holding academic positions, 84% were male and 16% female. Women made the highest showing in four-year colleges, 23.5% of Ph.D. psychologists. In two-year colleges, the men outranked the women more than anywhere else at 87%. In the universities more men were in tenured positions; they made more money and taught fewer hours than women. They had more articles published but regardless of that or their degree, they tended to have higher ranking positions. Women often worked in other areas, such as clinical psychology, before teaching. They were slightly older than their male counterparts and usually were single.

By 1978 matters had improved very little for women. Over (1982) found that more men than women had pub-

lished and women published less and less as they got older. Women still had not moved into research and were more likely to be unemployed or underemployed. One reason cited for these statistics is women's lack of connections necessary for publication and research (Over, 1982), as well as family responsibilities (Russo & O'Connell, 1980). Women in other areas of psychology were experiencing the same disproportionate pay and status (Russo et al., 1981).

The year 1981 brought little change. However Russo et al. (1981) had found "no substantial differences in salaries among sex and minority-status groups within rank and years in rank categories" (p. 1321). Of course white men made the largest showing in the top positions and the tenured positions, e.g., in graduate psychology departments women made up only 21% of the faculty. "Women and/or minority group individuals are less likely to be tenured, more likely to have lower academic rank, and more likely to be represented among faculty with joint or part-time appointments" (p. 1321). Also women and minorities often left positions before tenure decisions were made. Research did not show whether they left because they wished to move up and saw no way to do so, or if some other factor affected their choice.

Russo and VandenBos (1981) reported discrimination similar to that found in academia within the mental health system:

> Women are well represented in the mental health delivery system. Based on a sample of 321 federally funded community mental health centers (CMHCs) in 1976, women represented 82.7 percent of the clerical and maintenance staff, 61.6 percent of the paraprofessional staff, and 53.2 percent of the professional staff (Bass, 1978). The percentages of women increase as the broad category of occupations decrease in training, prestige, and income. The same trend is evident when the specific professions within the "professional staff" category are examined. Women represented 11.9 percent of the psychiatrists, 17.3 percent of the non-psychiatric physicians, 28.3 percent of the psychologists, 56.2 percent of the social workers, and 94.1 percent of the nurses (Bass, 1978). In one study of federally funded projects comprised of alcohol projects, drug projects, CMHCs, comprehensive health centers, family planning clinics, and vocational rehabilitation, 80 percent of the projects were directed by men (Naierman, 1979) (p. 413).

On governing and advisory boards women were underrepresented, especially as presidents of the boards.

Kitchener, Corazzini, and Huelsner (1975) were aware of the inequality in the mental health system, and in 1975 they asked "What does it take for a woman to be hired?" They sent resumes to directors of a number of counseling centers to be rated in terms of the candidate's ability to perform clinical services and the likelihood of their being hired. The directors were also asked to fill out an instrument which showed their own level of self-acceptance. The resumes were very similar: one was meant to be a traditional female; one of unspecified sex; and the third a feminist who had experience which was similar

to the traditional woman but with added experiences counseling women, e.g. rape counseling.

The study showed that the higher the level of self-acceptance of the male directors, the higher they rated all the candidates. The feminist candidate was rated higher by the director than all the others "on potential to deal with a wide range of emotional problems and on preparation to develop outreach programs" (Kitchener et al., p. 444). However she was not rated any higher than the others on her chance of being hired. Some of the directors wondered if she would be able to get along with other staff members. In their conclusions the researchers conjectured that when a woman is more skilled than her colleagues, she may also be perceived as difficult to work with and therefore may not be hired, especially if that skill concerns feminist politics. Directors, however, were not asked their reasons for choosing to hire a particular candidate.

In research organized by Kimmel (1974), Piacente (1974) devised a study which would test the hypothesis that: 1) women perceived as competent would be perceived as less feminine that those women perceived as incompetent; and 2) "the professional efforts of females will tend to be judged less favorably than those of males, provided some ambiguity exists regarding the competence of the individuals judged" (Piacente, 1974, p. 527).

Videotapes of two male and two female actors conducting an experiment were shown to 214 male and female undergraduates. The actors each acted competently in one videotape and incompetently in another. Sex of experimenter showing the tape was varied. Each subject was asked to complete a semantic differential after viewing the tape.

The factor analysis showed that on the competence-incompetence scale, "when there is little ambiguity as to their competence, women and men are judged to be equally competent, but when there is reason to doubt competence, women are perceived as much less competent than men--more so by men than by women" (Piacente, 1974, p. 529). On the masculine-feminine scale, incompetent women were rated as more feminine than competent women. Incompetent males were also rated as more feminine than competent males, but only when a male showed the videotape.

Piacente (1974) applied this former finding to the issue of hiring practices, hypothesizing that if the competence of two candidates were ambiguous and one was male and one female, the male would be chosen. In terms of clinical practice, the findings could indicate that clients may be more likely to judge a female therapist rather than a male therapist as incompetent, especially if they did not improve or if there was any other ambiguity

in the situation. This may be true of supervisors as well.

Thus far women have been shown to be low in the hierarchy of academic and mental health organizations. The reasons cited include cultural, historical, and discriminatory practices. Women's internal barriers to upward mobility or their desires for such moves have not yet been addressed. The next section on personality characteristics looks at the women themselves and how they behave in the world of work.

Personality characteristics of female psychotherapists

Bachtold and Werner (1970, 1971) have done two major studies on personality profiles of women PhD psychologists. Although psychologists are not necessarily representative of all female psychotherapists, this research is presented here because this is where the literature is concentrated. When they studied three different generations of women, (n = 375), all of whom had been administered the self-report Cattell Sixteen Personality Factor Questionnaire, Bachtold and Werner (1971) found the younger women, those in the group with a mean age of 38, to be the most tough-minded and self-sufficient, but the least secure and most impulsive. The women under 50 but over 38 scored higher on ingelligence than the women over 58. "All three generations of women psychologists were

significantly more aloof, intelligent, dominant, flexible, adventuresome, unconventional, confident, radical, and self-sufficient than women in general" (p. 273). They said here that these women also experience conflicting sex-role expectations, with those women over 58 demonstrating this characteristic to a lesser degree than the younger psychologists. Interest in the traditional feminine role was less important to the psychologists than to women in general.

When describing the women psychologists, who were over age 58, Bachtold and Werner (1970) said, "Accepting and adaptable, open, and ready to take a chance, they are also more inclined to moralize" (p. 237). They are assertive and self-assured and not inhibited by "environmental threat" (p. 237) or pressure. The personality inventory showed that these women were also more intelligent than their male colleagues. The authors found a difference between women who worked as counseling psychologists and those who were developmental psychologists: "The differences found in the present study among women psychologists point to a more 'action and social relations' oriented personality among the counseling and educational psychologists, and a more 'intellectually independent, reflective, and self-sufficient personality among the developmental psychologists" (p. 240).

While these older women were seen as independent the younger women seemd to be plagued by a higher degree of conflicts. Doller (1979) in her research on single women in social work and psychiatry, developed research which found these women as beginning to internalize more competency-based traits, i.e., stereotypic male traits, but as still being viewed in a stereotypic feminine way. In Rider's (1975) opinion, this acquisition of masculine traits is a source of tension: "It appears that women are more anxious about competitive and aggressive behavior than are men" (p. 15). She also viewed women as struggling with success. In her opinion, they were taught to push towards success but then were told by the culture not to be successful. As she pointed out, this lesson adversely affected performance.

Not unexpectedly, given the conclusions stated above, suicide rates were high among professional women, as found by Mausner and Steppacher (1973) who conducted a study on the suicide rate of APA psychologists, one-fourth of whom were women in the early 1970s. It was projected from the general population that 5.7 of these women would have died from suicide. In fact there were 16. The men had fewer than projected, 34 instead of 46. The authors cited such reasons for these differences as role conflict, fear of success, and the difficulties women have had becoming integrated into the world of work. This research did

not study each woman but cited reasons based on the literature such as Rider's study (1975) cited above.

Adams (1971) and Carter (1971) both acknowledged the kinds of stereotypic behaviors women have in our culture.

> The main target of my concern is the pervasive belief (amounting almost to an article of faith) that women's primary and most valuable social function is to provide the tender and compassionate components of life and that through the exercise of these particular traits, women have set themselves up as the exclusive model for protecting, nurturing, and fostering the growth of others. Fundamental to this protective nurturing is the socially invaluable process of synthesizing diffuse and fragmented elements into a viable whole--a basic ingredient of any society's development and survival. (Adams, 1971, p. 401)

Adams, whose writing was not based on research, saw women using these skills on a large scale when they took jobs as social workers. Her warning to women was not to be used for these traits. She wanted women to really look at what they were doing and take a stance of greater integrity; if it feels rights, give up "the compassion trap" (Adams, 1971, p. 411).

Carter (1971), writing from her own experience, encouraged women therapists to capitalize on feminine traits when working with clients. Their interest in people and relationships and their ability to express a wider range of feeling allow women to understand and handle resistance and work with severely disturbed clients.

Duhl (Robbins, 1982) also emphasized the necessity of feminine traits in developing theory and working with clients. She believed women have a natural ability to synthesize and integrate, traits essential to Duhl's field of marriage and family therapy which she saw as in its integrative stage.

> Our culture seems to give permission for women...to think relationally. For me, that has a lot to do with what family systems are about, how things fit together, how people fit together. (p. 3)

However, McDaniel (1983) conjectured from her own experience that women need more training in conceptual skills and in the ability to theorize and explain what they perceive.

To summarize, practicing women psychologists have been shown by research to be more assertive, independent, and willing to take a risk than the average woman (Bachtold & Weiner, 1970, 1971). Although these women experienced discrimination (Russo & VandenBos, 1981) and perhaps often endured role strain (Rider, 1975), they were still out in the world making an impact as women. These more stereotypically masculine characteristics seem important for women family systems therapists. The family system theory demands that women be in a powerful position in the therapy room (Caust et al., 1981), regardless of the kinds of interventions made, i.e., that they not be viewed simply as supportive or as having a passive role in

the client's changing. In the next section how women have conducted themselves thus far in the therapeutic process will be addressed.

Male and female therapists and the therapeutic process

Although there has been a great deal of literature on treating women mental health patients, studies of women therapists and how they work are scarce. In most of this research women and men have been compared. Much of it was done on trainees using undergraduates as clients. Taken as a whole, this body of literature seemed self-contradictory and dependent on other variables besides sex of therapist, e.g., race, age, experience, and the therapist-client relationship. Also, studies often isolated certain variables, rather than looking at the therapeutic relationship or the therapist as a whole. Therefore, the studies must be viewed in terms of how well or how poorly they have built on one another and what results came from replications of the studies (Fiske, 1977).

The majority of research has been on individual therapy rather than group, marital, or family therapy. There was an assumption that, "Being a psychotherapist means, on one hand, being an empathic listener, providing basic acceptance, understanding, and trust. On the other hand, being a psychotherapist means being active, analytical, and in charge of guiding the client" (Yogev &

Shadish, 1982, p. 545). This means a balance of stereotypic masculine and feminine traits, with the characteristics of empathy, trust, and understanding being typically more female and the characteristics active, analytical, and in charge being typically male.

Researchers have often presumed a psychoanalytic stance. Here the importance of transference, the directing of childhood material onto the therapist, and of countertransference, "The sum total of the therapist's reactions to the patient," (Bieniek, Barton, & Benedek, 1981, p. 131) including unconscious material, is highlighted. The research has made the assumption that countertransference material for men and women is different because men and women are different; as is seen, the literature has often implied the idea that this may have meant women were less effective (Jackson, 1973). It is important to bear in mind the above mentioned perspectives when reviewing the literature. Also it is implicit that unless otherwise stated, only white therapists were studied.

Individual therapy

Various aspects of the therapy relationship in terms of female/male therapist differences have been studied. Rivero and Bordin (1980) looked at initiative, or directive, behavior of 22 therapists, 11 male and 11 female. Each therapist interviewed two women, one they

all interviewed and one who was different for each of them. The authors used Strupp's Initiative Scale which was designed to distinguish the extent to which the therapist directs the verbalizations of the client. They found that sex of therapist in working with female clients had no impact on the therapist's ability to direct the verbalizations of the client. Unfortunately drift reliability was low although the authors explained it away as "an accident in which the check samples happened to consist of a set of responses considerably more homogeneous in initiative" (p. 124). The authors compared their study to Parker's (1967) which they stated showed that male therapists were more directive with male than with female clients. Actually it showed the male therapists were equally directive with male and female clients, but used more non-directive responses with female than with male clients.

Parker (1967) had given 16 male graduate students with no more than two years of counseling experience the Gough Adjective Checklist which is a report of personality characteristics. He compared the Dominance-Nondominance category with the Directive-Nondirective verbalizations of the therapist in two initial interviews, one male and one female client. Those therapists who scored high on the dominance trait were found to have the highest proportion of directive interactions with patients. However, they had equal scores on non-directive behavior. The non-

dominant therapists had many more non-directive responses than directive.

A different study done in 1979 (Berman, 1979) focused only on the therapist. Berman, whose study was one of the few that included race comparisons, asked participants to respond to a role-played videotaped vignette of a white client. She found that white male and white female therapists tended to use a more passive, attending style, that is, "open questions, closed questions, paraphrase, and reflection of feeling" (p. 82), with white women making little use of expressive skills, "directions, expression of content, expression of feeling, interpretation, and direct mutual communication" (p. 82). Blacks in this study used more expressive skills than attending techniques.

Blaas and Ginsburg (1979) based their study of psychotherapy on the belief that counselors need to adapt to the clients structure of communications and understand clients from that perspective. They redesigned the study of Berlin and Pearson (1978), which had shown no difference between male and female counselors in how they would handle clients using the Counselor Response Inventory. Where Berlin and Pearson used written information on clients, Blaas and Ginsburg had actors act as clients. After giving the therapists the inventory they found no

difference for male or female counselor trainees regardless of sex of the client.

On the issue of empathy there were two very different studies which gave conflicting results. Olesker and Balter (1972) found that males and females in general did not differ much in their ability to show empathy. "However significant differences were found between same-sex and other-sex groups, supporting the hypothesis that individuals will show more empathy when judging people of the same sex than when judging persons of the opposite sex" (p. 559). Their study had been conducted at a private liberal arts college and involved 48 male and 48 female white students aged 16-26. Each was given the Affective Sensitivity Scale which shows a videotape and asks subjects to mark what they think the actor feels. It is unclear if these results might carry over to professional psychotherapists.

Persely, Johnson, and Hornsby (1975) found women therapists were more positive towards clients than male therapists were and also reported females had more empathy toward the client than did men. They showed 20 therapists-in-training a real session of a 19-year-old female with therapist comments deleted. The subject filled in his or her own responses. A Likert Scale for rating the patient on certain dimensions was also given.

Hill (1975) taped actual sessions of 12 male and 12 female counselors, one-half of whom were practicum students and one-half interns or staff with at least two years of counseling experience. She classified each counselor statement in terms of empathy and focus on feeling vs. being more active and directive. Both clients and counselors filled out satisfaction questionnaires. Hill's study, like Olesker and Balter's (1972), found therapists working with same-sex clients to be more empathetic and focused on feeling than when working with clients of the opposite sex. In addition, she found that in this situation the counselors tended to be more directive.

Hill also found a difference between experienced and inexperienced counselors. Inexperienced counselors were more empathetic than experienced counselors. This group also tended to discuss their own feelings more when working with members of the opposite sex. In studying client satisfaction she found that clients of women therapists were more satisfied with their counselors than clients of male counselors. Women counselors in general were found to be "more satisfied, empathetic, and involved" than the males (p. 10). One possible explanation for this finding is that women are traditionally perceived as empathetic and involved with other people.

Inexperienced male counselors were viewed as more like experienced female counselors--active and empathic:

> The most empathic, active, and satisfied counselors were experienced females and inexperienced males. Perhaps females need to gain experience before they feel confident in their skills and can be genuinely competent. Males, on the other hand, may lose interest in counselor skills once they acquire them and may move on to other areas of interest, areas more suited to stereotypic sex-role activities, such as administration, teaching, and research. (Hill, 1975, p. 10)

This study did not look at whether clients got better, only how clients felt about therapists and how therapists behaved in the presence of clients.

Rice, Burman, and Razin (1974) used a self-report questionnaire to assess the correlation of sex, style, and theoretical orientation. Eighty-six therapists rated themselves on the frequency of certain behaviors. The researchers found that experienced women reported themselves as using a wider range of therapy behaviors and as being "less anonymous in their therapy" (p. 417) than experienced males. There were also differences between experienced and inexperienced therapists with experienced therapists having an interest in history, demonstrating more patience, offering a wider variety of behaviors, and sharing more of themselves (findings contrary to Hill's (1975) more objective research) than inexperienced therapists (pp. 417-418). Age rather than clinical experience were offered as reasons for therapist selection of the first three factors.

Rice et al. (1974) tested the validity of the use of self-report by having the co-therapists of the subjects fill out the same questionnaire on their partners. Correlations of responses were considered acceptable.

The issue of experienced vs. inexperienced therapists was addressed by Auerbach and Johnson (1977) in their review of the literature on that topic. They first noted some controversy in the field as to what number of years makes one an experienced psychotherapist. The editors' notes suggested that an experienced psychotherapist is one with three to four years of full-time clinical experience (p. 101) while the authors suggested greater than five years. Either of these figures are important to bear in mind when reviewing the literature which often breaks down experience and inexperience by whether the sample population is in their first year of graduate school or last.

After completing their review on the influence of years of experience on outcome, Auerbach and Johnson (1977) noted that "the recurrent but not universal finding is that experienced therapists tend to be more active and confrontive" (p. 86) than inexperienced therapists.

Parloff, Waskow, and Wolfe (1978) in their review of outcome studies, said their "conclusions are even more pessimistic than those of Auerbach and Johnson" (p. 240) because in their opinion "the body of data available is

not sound enough to permit us to draw any firm conclusions" concerning outcome (p. 240). They did not, however, include some of the studies which Auerbach and Johnson did include on therapist ratings outcome.

Parloff et al. (1978) also drew similar conclusions about the studies of sex of therapist. In looking at "the sex of the therapist independent of the patients treated" (p. 236) they found only two out of seven studies which reported any differences in outcome (see p. 236). One of these was Hill (1975) cited above. However, they questioned her findings because no long-term outcome was measured, and they challenge the other studies on methodological grounds as well.

Turning back now to some other studies of differences between male and female therapists, which Parloff et al. (1978) did not review, it is important to take note of the now famous study of Broverman and his colleagues (Broverman et al., 1970) which showed that therapists, like the general public, had preconceived notions about the characteristics of healthy men and healthy women. These characteristics were based on the sex-role stereotypes which are pervasive in our culture and are limiting to men and women. Seventy-nine clinicians (46 men, 33 women) were given the Sterotype Questionnaire which consists of 122 bipolar items of gender personality characteristics. Each clinician was asked either to describe a

healthy mature adult, a healthy mature male, or a healthy mature female. Findings showed the healthy adult to be the same as the healthy male and the healthy female to have a different set of characteristics.

The question that Billingsley (1977) asked was, "even if a given clinician holds certain attitudes about what constitutes mental health in males and females, does this imply that the clinician will seek to increase the occurrence of sex-role appropriate behaviors in clients as a goal of treatment?" (Billingsley, 1977, p. 251), i.e., does the therapist respond to the pathology, the sex of the client or both? For the study, thirty-two male and thirty-two female therapists working in public mental health settings were given written descriptions of two fairly typical clients; one was clearly explosive, the other with more nebulous complaints but more passive, restricted behaviors.

Differences were found between males and females irrespective of experience. "Female therapists saw the explosive client as having a worse prognosis than did male therapists. Female therapists also saw the restricted client as having a better prognosis than did male therapists" (Billingsley, 1977, p. 254). From the list of stereotypic male and female behaviors used in the Broverman study, men and women chose different treatment goals. "Male therapists chose more feminine treatment

goals for their clients, and female therapists chose more masculine treatment goals for their clients" (Billingsley, 1977, p. 255). Examples of female traits were passivity and nurturance; examples of male traits were independence and assertiveness. Billingsley concluded that each therapist tried to broaden his or her client's supposed repetoire of behavior.

Billingsley's (1977) study is empirical research which contradicts Van Hook (1979) who in an essay warned that when women see women clients they may inadvertently support learned helplessness, a stereotypic feminine behavior. She feared that when women clients saw men for treatment, the context simply reinforced the role of the helpless woman who must depend on men. She therefore prefered that women therapists see women clients and that women consciously act as role-models to other women. Her assertions regarding what happens in therapy were not supported by research.

Alonso and Rutan (1978) agreed with Van Hook's (1979) opinion that there is a collusion between male therapists and female clients to avoid issues of aggression. In their opinion, which was not based on research, such things as money and long-term career goals are not usually discussed in these situations. They thought that one way to handle this discrepancy was for

the male therapist to have a woman supervisor who is willing to take a political, feminist stance.

Jackson (1973) had concerns for women therapists when they see clients, especially male clients. In her experience patients preferred to see men. "When a woman is in charge of treatment, resistance and transference may be heightened. Issues about femininity arise, especially relating to aggressiveness. The content of therapy may be altered" (p. 7). Here it was unclear if Jackson placed a value on this altered content. Jackson went on to say,

> It is not unusual for patients to be reluctant about entering treatment. But when an unexpected event occurs, such as being assigned to a female therapist, there seems to be an intensification of doubt about the necessity for treatment or the benefits that will accrue. The patient may have a pronounced tendency to feel that his problems are not really that bad or to question how useful treatment would be. Resistance may be expressed by comments regarding the place women occupy in this society and statements about women aspiring to be in positions not in keeping with their nature. Resistance may also emerge as negative comments about women's capability. Some patients inquire about the female therapist's personal life, in an effort to effect a peer rather than a doctor-patient relationship, and make more searching inquiries concerning her education. (p. 7)

Jackson's point was that because of the clients' (and their own) sex-role stereotypes, she believes women therapists may have more difficulty than men forming an alliance with the client. The issues of gender need to be dealt with both culturally and within the client-therapist relationship, said Jackson.

This section addressed a range of issues dealing with the therapeutic process of individual therapists. There was a concentration on the way women conduct therapy in comparison to men. The next section is a brief focus on the family therapy process as it pertains to women in comparison with men. Later the process of family therapy is discussed followed by a more detailed analysis of the literature on the execution of family therapy skills, with a focus on the writings concerning women.

Family therapy

Personal perspectives.

In their essay on the "Challenges and Promises of Training Women as Family Systems Therapists," Caust et al. (1981) proposed that women therapists meet many difficulties in practicing structural/strategic family therapy. They agreed with Jackson (1973) that society expects certain stereotypic behaviors from women and reiterated that perhaps clients are surprised if a woman assumes a power-laden, directive, active role. They asserted that this role is an important one for a family therapist. However, they used feminist and sociological theory to give credence to their belief that the role is a difficult one for many women to operationalize given their own sex-role learning and that of their clients (Caust et al., 1981, p. 441). The discri-

mination present in their work life may also make authoritative behavior difficult.

McDaniel (1983) drew from her own experience in her view of women family systems therapists. She saw them as having little trouble joining or forming alliances because little girls are taught how to do that. Both she and Caust et al. (1981) were of the opinion that it is the way women use these relationships in the family therapy which may not be helpful at times. They may become too much a part of the family and thereby lose perspective, rather than joining as an expert or from a distance which allows her to use her skills to help the family change.

Empirical research. There has been little empirical research into the behavior of family therapists or the effects of therapist gender in family therapy. In one such study, Beck and Jones (1973) did an extensive survey of family agency services and found that male therapists were more successful than female therapists in getting and keeping husbands in therapy conjointly with their wives. They found no other gender differences

The McMaster group in Hamilton, Ontario (Woodward et al., 1981) did a comprehensive study of 279 families in treatment at their training center. The male therapist trainees in their study tended to be psychiatry residents, psychology interns, or family practice residents and therefore of higher value in society's hierarchy of profes-

sions. These therapists "reported slightly greater change during treatment in the families they saw. . .and also were slightly more likely to have satisfied clients." The women therapists, who were from the less prestigious fields of social work and nursing and who also probably had less clinical experience, gave their clients worse prognoses and lower ratings of change than did the male trainees. When goal attainment and recidivism were explored it was found that sex of therapist had nothing to do with actual outcome. According to the authors, this comparison of outcome with the therapists' opinion of the family and change showed that the women tended to underestimate themselves and their effectiveness. Parloff et al. (1978) had also found little difference in outcome between male and female individual therapists. Billingsley (1977) had found gender differences in therapists' prognoses of specific kinds of clients. This was replicated in the McMaster study with the addition that women viewed themselves as less effective than the men did.

Gurman and Kniskern (1978) questioned the results of the McMaster group with a slightly different interpretation of the results from the one the researchers gave. In the opinion of Gurman and Kniskern, the McMaster "results are undoubtedly contaminated by the clear hierarchical therapist prestige structure in Canada" (p. 874), where

male-dominated psychiatry is clearly more valued than the female-dominated social work and nursing professions. Their objection, as well as Woodward et al.'s (1981) comment concerning women's tendency to underestimate themselves, was a reminder of the importance of context and societal influences in designing, interpreting and reviewing research.

Summary. Overall, research has shown few consistent differences between the practice of male and female psychotherapists. That research which has been done has tended to isolate certain variables such as therapist's commitment to the client or empathy. Some authors have simply asserted what they considered fact based on personal experience, e.g., Jackson (1973) and Caust et al. (1981).

Family therapy bases its theory and technology on the interaction of variables and the circularity of patterns of behavior. Implicitly individual therapy, too, depends on the interaction of a wide number of variables (Orlinsky & Howard, 1980). Ideally, in studying therapeutic process, the context, the theory, the methodology, and many other variables must be studied together in order to determine what part gender of therapist plays. Also studies are needed which involve observation as a supplement to self-report. Given the nature of psychotherapy,

the technology to do this kind of research has thus far been cumbersome or costly.

Training and supervision of male vs. female therapists

Implicit in the literature on supervision of therapists is an assumption that it usually is a one-to-one, hierarchical process with the supervisor in charge of the therapist and the case. It takes place separately from the therapy. Being supervised with live supervision is the exception rather than the rule. Also most of the literature has assumed a psychodynamic, individual perspective. This literature on training and supervision which looks at male-female differences, is concerned with two major areas: 1) how do women make the transition from student to therapist? and 2) what supervision issues are important in terms of countertransference? In this group of studies there is an assumption, either implicit or explicit, that the process of therapy for male and for female psychotherapists is different. The difference leads to a difference in outcome for the client. The literature implies that the client may suffer if he or she has a female therapist.

Yogev and Shadish (1982) were concerned with how sex-role stereotypes affect trainees who are beginning to see clients. This study, whose goal is reminiscent of the Billingsley (1973) study cited earlier, had as its goal

"to develop a means to assess how sex-role stereotypes affect therapeutic interventions and influence clinical work" as far as expressive/nurturant vs. authoritative/instrumental behaviors are concerned (p. 545). Each of 23 female and 15 male graduate counseling psychology students was given the Bem Sex Role Inventory which is a self-report scale which measures personality characteristics on a continuum of feminine-androgynous-masculine. Therapy sessions were recorded and verbatim transcripts made. A male and a female therapist, who were described as experienced, rated the transcripts on the Yogev Therapist Activity Style Scale. This is a semantic differential instrument. The authors found that beginning female therapists were less likely than men to be rated directive or active in the session, even those women who viewed themselves as androgynous. Males were found to be rated more evenly. The authors suggest a closer monitoring of the women trainees to insure a broader range of behaviors. In comparison, Hill (1975) had reported that with experience female therapists became more active and directive.

Two authors have noted difficulties they observed when certain women entered internships. Benedek (1973) found the hospital administration where she worked to be sexist as well as her supervision to be lacking around issues of difficulties due to her sex, i.e., pregnancy, role strain. Pleck (1976) pointed out the same kinds of

difficulties women have. He noticed that when new male and female interns with identical training entered an inpatient internship, the men affiliated with the first year psychiatric residents and the women with the female nursing staff. In this situation a hierarchy of sex rather than a hierarchy of position existed.

Gallessich, Gilbert, and Holohan (1980) developed a course to address the difficulty described above. Their perspective is both societal and individual:

> Students and other initiates are required to accomplish significant changes in their power concepts. Between the time of entry into professional training and completion of that training, students move from positions of relatively low power to positions of responsibility and authority. The behavioral changes required in this transition often involve significant revisions of self-concept, especially in perceptions of the relationship of one's own power to that of others in the working environment. Although for some the greatest difficulty comes at the entry into training when the low status of student must be accepted, for others the movement into full professional responsibility is the period of most ambivalence, stress, and inappropriate behavior. . . . The novice is suddenly an authority, the person with whom the "buck" stops. (p. 15)

These researchers developed a training model to help students through these difficulties. It was targeted for women but men also found it helpful. The course was designed to help the students "explore the impact of sex-role expectancies on power-related attitudes and behaviors and to increase their leadership effectiveness" (Gallessich et al., 1980, p. 15). The students developed

goals in terms of new behaviors they wished to acquire in areas such as initiating and questioning and worked in class using role-play and devised situations to meet their goals. There was no follow-up to see how the students did in actual work situations although they all reported meeting at least some of their goals.

Abramovitz and Abramovitz (1976) also saw the move to practicing her new profession as difficult for some women therapists. They addressed the problems of a role shift in terms of beginning to see clients and to have supervision:

> Beginning supervision is a critical developmental hurdle for the aspiring female psychotherapist. In symbol and in fact, it is a rite of passage from the sanctuary of book learning to real-world decision-making. Since the skills required by the former endeavor more closely fit the feminine sex role convention of passive dependency than do the assertive and risk-taking demands of decision-making, the transition for the female supervisee can be fraught with ambivalence and ego-protective maneuvering. (pp. 583-584)

Rather than offer the woman student a course on handling these difficult issues, Abramovitz and Abramovitz (1976) offer her potential supervisors advice on dealing with her and suggestions on what behaviors to give special attention, i.e., transference manifestations.

According to the authors, one major difficulty new women psychologists have is breaking role patterns learned in a family, especially a traditional one. Because of her family background a woman will come to her supervisor with

certain expectations of herself; "certain aspects of traditional family life render the quest for competent and independent functioning, especially difficult for the preprofessional woman" (p. 585).

These difficulties will lead to task avoidance behavior in the woman, said the authors. She may use intellectual seductiveness for example, ask the supervisor if she can borrow his books, or let the supervisor know he is the best she's ever had. She may put off taking her first case, or criticize her skills.

> It may soon become apparent that the female trainee grossly undersells her level of clinical expertise at the outset of supervision. She may be reluctant to carry all but the most straightforward cases involving mild psychopathology. She also may be hesitant to do therapy with men, an empirically established finding that underscores the conflicts activated in women by the expectation of having to exercise authority over men.
>
> More often than not, such ego-protective gymnastics by female students stand in bold relief against the supervisor's impression of their clinical precocity relative to their male counterparts. (Abramovitz & Abramovitz, p. 586)

Women, assumed the authors, have an intuitive sense of dynamic processes because of sex-role learning, but, for the same reason, have difficulty staying in charge; they may allow extra sessions or may underestimate the severity of pathology, not take control of the pace of a session, so that the client's therapy "may tend to drift lazily along at the patient's whim" (Abramovitz & Abramovitz, 1976, p. 587).

It may be difficult, the authors further assumed, for women to give up their dependence on their supervisor. Near the end of supervision women may have crises with cases for which they previously used only light supervision.

Abramovitz and Abramovitz (1976) gave advice to the male supervisor to help him avoid counter-transference pitfalls. He must be aware of his own process and whether he needs his supervisee to boost his self-esteem. He should then outline for the supervisee the developmental process she may go through. Together they should decide whether her material about men will be discussed in the supervision.

The woman supervisor, they said, may bring up different issues for the female supervisee. In their experience, if the supervisor is traditional, a more liberated supervisee may want to raise her consciousness. If she is more liberal, the supervisee may want to punish her for stepping out of role. The supervisor herself may give away her authority and may end up consulting the supervisee on her own cases.

These authors made many sweeping generalizations which may or may not be true. They fail to address whether male supervisees have similar difficulties. However, they raise issues similar to those raised later in this review by those who critique women family systems

therapists. Unfortunately, the assertions made are not all backed by empirical findings.

McDaniel (1983) addressed the needs of female family therapy trainees from the perspective of her many years as a supervisor. She and Tollers (1983) agreed with Abramovitz and Abramovitz (1976) that women have some difficulties in the therapy room which result from gender stereotyping. However, McDaniel gave a different perspective from Abramovitz and Abramovitz in how to handle it. She suggested helping women students increase conceptual skills by having them participate in critical discussion and the theoretical conceptualization of their cases. She suggested that women supervisors act as role models. Both Reid (1983) and McDaniel suggested the trainee be told to pretend she is a certain way to allow her to try new behaviors rather than try to rework personal issues.

Reid (1983), who saw women as getting trapped in a "dependent mind stuck (DMS)," suggested that supervisors use live supervision practices which leave the supervisee on her own except when she gets stuck. At those times any difficulty should be framed as external to the trainee rather than something wrong with her, and new behaviors must be offered for her to try.

Summary. The literature reviewed on supervision emphasizes the needs of the female supervisee. Only one article was based on research. The personal perspectives

of the authors cited must be seen as mere speculation until empirical data are gathered. There is research on supervision in general but there is a dearth of material concentrating on the needs of male trainees, and also which focuses systematically on helpful and unhelpful behavior of supervisors.

Conclusions and implications

As stated earlier, much of the research on therapy process and outcome is contradictory, particularly regarding the effectiveness of the skills of women therapists. Besides reviewing research this section of the literature review has included essays by various authors on their experiences in the field. Little research or personal reports were found concerning female family therapists or family therapy at all.

In this section, several conclusions and implications can be drawn.

1) Within the larger context of the workplace, women psychotherapists face discrimination constantly. They are rarely in power positions and the literature often assumes implicitly that they want to be in more typically male-dominated positions. Given their places organizationally, it may be difficult for women to take positions of power within the therapeutic context. This difficulty or lack of demonstrated power could directly

affect their ability to assist clients and enhance the place of women in the profession.

2) In studying the therapeutic context, researchers have isolated different variables in their efforts to find differences between male and female therapists (e.g., Rivero & Bordin, 1980; Berlin & Pearson, 1978). These studies are often contradictory or limited and must be reviewed and replicated more systematically. The question of which sex makes the better therapist with which clients is unanswerable with available data.

3) The way clients view their therapist <u>is</u> important. Also the behaviors they expect from the therapist are important for the therapist to understand in order for her or him to design the best treatment plan. Family therapy literature does not really address this issue. Family therapists need to take something from the literature in this area in order to better understand some client behavior and family interaction. To assume the client views the therapist as in charge may be incorrect. Women therapists definitely may be viewed by the family as a woman first with stereotypic female behaviors, and not as the expert she is. This will affect the means women may use to produce change, and perhaps the willingness of certain family members to participate.

4) Broverman et al. (1970) showed therapists may view clients in sex-stereotypic ways. Family therapists

and other therapists may make assumptions that client change should be in the direction of traditional roles or ways of behaving (Hare-Mustin, 1978). Billingsley (1978), however, showed both male and female therapists report attempts to help either sex clients broaden their range of behavior regardless of gender.

5) Supervision can be the place where sex-role stereotypes are broken. Either in traditional one-to-one supervison or the live supervision models commonly used in family therapy training, supervisors must be aware of how sex-role stereotypes can limit behavior. They can then introduce new behavior options to all their trainees within this context of training and experimentation.

6) The experience of the female family therapist has not been studied thoroughly through research. Caust et al. (1981) and McDaniel (1983) had many speculations about her but no empirical research. It might be guessed that she has trouble assuming her position of authority. In strategic or systemic family therapy the therapist often chooses a one-down position. The female family therapist may not have that choice, but be forced to that position given cultural expectations. The therapist needs a flexible range of behaviors available to her and sex-role stereotyping may limit her behaviors. This may also be true for men, a point which needs to be addressed in the research.

There will now be a shift to the literature on family therapy theory, especially where it emphasizes the expectations for therapist behavior.

Structural, Strategic, and Systemic Family Therapy

Family therapy is a relatively new context for therapy with new expectations for the therapist. One theme that is central throughout the structural and strategic family systems models is the necessity of the therapist to be able to have control of the therapy (Haley, 1976; Minuchin and Fishman, 1981; Fisch, Weakland, and Segal, 1982). In addition, important behaviors for the therapist may range from the more overt, directive, instrumental kinds of actions (Haley, 1980) to the therapist's consciously taking the one-down position (Watzlawick et al., 1974), to the therapist's taking a neutral position in the therapy room (Selvini Palazzoli et al., 1980).

This section of the literature review will look briefly at the four theoretical models which make up structural, strategic, and systemic family therapies. A discussion of the kinds of interventions used in each school will be included. Places where the techniques and theories overlap will become obvious.

Minuchin and Structural Family Therapy

Structural Family Therapy was developed by

Salvador Minuchin and his co-workers at the Wiltwyck School for Boys (Minuchin, Rosman, & Baker, 1967).

> Minuchin and his co-workers developed a therapeutic approach that was founded in the immediacy of the present reality, was oriented to solving problems, and was above all contextual, referring to the social environment that is both a part of and the setting for an event. (Aponte & Van Deusen, 1981, p. 310)

Although practice came before theory, its theoretical underpinnings are from General Systems Theory, using most often the concepts of boundaries, subsystems and the interrelationship of parts. Dysfunctional families have patterns of interactions which may improperly cross boundary lines or in some other way limit members. The goal is to change the structure to allow for symptom alleviation and more general and interpersonal flexibility, as well as appropriate normative tasks.

The therapist's use of self is very important. "Of major importance therapeutically is Minuchin's inclusion of the therapist as an active intruder, changing the family field by his very presence" (Hoffman, 1981, p. 264). It is the process just as much as the content which restructures. The therapist influences the family process with the choice of to whom he speaks, by the order, or by whom he blocks. He or she disrupts patterns of interaction, sometimes using his or her entire body for emphasis. "He does not point it [a particular pattern] out or challenge it, but interferes with it by the way he directs

personal exchanges with and among all family members" (Hoffman, 1981, p. 266).

Structural family therapists work to change the family organization so that symptoms disappear and the family and its members can interact with more flexibility. ". . . change occurs when there is a system transformation which develops a new capacity among family members to select alternate ways of relating" (Minuchin et al., 1978, p. 90). The job of the therapist is to take an active role "to uncover more effective alternative transactional patterns in the therapeutic system and to foster their use" (Minuchin et al., 1978, p. 86).

Minuchin recognizes that the very presence of the therapist has an influence on the family, whether or not any intentional move has been made. The context itself is one where the therapist is in charge of change, regardless of whether the family is there by court order or by its own free will.

"When the therapist joins the family, he assumes the leadership of the therapeutic system" (Minuchin, 1974, p. 111). He or she moves in as the expert and takes control. This does not mean that he or she is unaware of the forces which are acting against his/her influence (Minuchin & Fishman, 1981). The important point here is that the therapist installs himself or herself as the leader who is an expert in making the family better. "In

most cases the family will accept the therapist as leader of this partnership. Nevertheless, he will have to earn his right to lead. Like every leader, he will have to accommodate, seduce, submit, support, direct, suggest and follow in order to lead" (Minuchin & Fishman, 1981, p. 29). Structural therapy is quite explicit that the therapist must use a wide variety of skills in order to be effective.

Joining is one of the most important aspects of structural work in that if the therapist has joined well he or she can hold the family in treatment during difficult times. The structuralists imply the limited use of sharing of self. The therapist uses those parts of herself or himself which are congruent with the client, but does not reveal so much that she or he becomes powerless.

> In forming the therapeutic system, aspects of himself that facilitate the building of common ground with the family members will be elicited. And the therapist will deliberately activate self-segments that are congruent with the family. But he will join in a way that leaves him free to jar the family members. (Minuchin & Fishman, 1981, p. 32)

In joining the family the therapist once again has used several skills. She or he has established herself or himself as leader. She is the expert who can, if necessary, also use parts of herself to increase the family's identity with her. In establishing this relationship she also establishes herself in a position of being able to grant or remove rewards, almost like a parent to the

entire family. At times of high stress the therapist's ability to reward with understanding or confirmation may be what holds them while the therapist pushes them beyond their normal limits (Minuchin, 1974). Thus Minuchin stresses the importance of forming a therapeutic alliance.

In order to reach his or her goal of alleviating family dysfunction, the structural therapist challenges the family. She or he challenges their definition of the symptom, challenges the family's organizational structure, its boundaries and patterns of interaction, and the way the family views reality. "Challenge can be direct or indirect, explicit or implicit, straightforward or paradoxical" (Minuchin & Fishman, 1981, pp. 67-68), however, structural therapists tend to take a directive stance using paradox only occasionally (Minuchin & Fishman, 1981).

Structural family therapists fall on the side of direct influence in the kinds of interventions they make. They may often use nonverbal directives, as when they may hold their hands between parent and child in order to interrupt eye contact, but these interventions are still direct. They are not usually so direct that they would say to a mother, "Stop answering for your child," but would say something to the child like, "Your mother feels she must work hard for you?" They comment fairly clearly and actively on the interactions.

Structural therapists rely on their abilities to join with first one and then another family member in a planful manner which will unbalance the system. There is a sense in the methodology of the therapists' using their bodies and their minds in the carrying out of interventions.

The Brief Therapy Project of the Mental Research Institute (MRI) and the Interactional View: Strategic Therapy or Brief Therapy

Watzlawick, Weakland and Fisch, of MRI, (1974) have developed a form of family therapy which focuses on the symptom and how the family's patterns of interaction maintain that symptom. The theory underlying the practice is also General Systems Theory as used by the Bateson Project (Bodin, 1981).

The goal of the therapy is the alleviation of the symptom (Bodin, 1981). The therapist operates in the present looking not only at interaction or process but also at how the family or client defines the problem and what the expectations of the symptom bearer are.

As with Structural Family Therapy, the therapist is in control of the sessions. "MRI therapists tend to be active and directive using a vast array of techniques" (Bodin, 1981, p. 296). The goal is to break the symptom maintaining cycle which has inadvertently been established. The therapist must remain free "to take purpose-

ful action despite fluctuating obstacles or restrictions" (Fisch et al., 1982, p. 22). She or he works for small changes, which when "appropriately and strategically directed" (Fisch et al., 1982, p. 19) reverberate throughout the system.

Watzlawick et al. (1974) outline a four-step procedure which the therapist must go through in order to facilitate change:

1) a clear definition of the problem in concrete terms;

2) an investigation of the solutions attempted so far;

3) a clear definition of the concrete change to be achieved;

4) the formulation and implementation of a plan to produce this change. (p. 110)

Like Minuchin, they are present-oriented and problem-focused. However, this group sees problems forming in families or clients because 1) there is a consistent reapplication of the same wrong solution; 2) there is a denial of the problem; 3) there is an insistence that the situation can be better or the client views a difficulty as a much worse problem than it is; 4) there is a desire for another to act spontaneously in a context where that is impossible, e.g., a father's insisting that his child

wants to change takes away the child's ability to change spontaneously (Watzlawick et al., 1974).

The kinds of interventions the therapist uses depends on a number of variables which can be assessed when the four previously mentioned steps are followed.

The theory of therapy states explicitly the therapist is in charge:

> In family therapy as developed by MRI, the therapist controls the session to a very great degree. Therapist control may not be overt at all points, since the therapist may appear to be following the patient's lead in various directions. (Bodin, 1981, p. 296)

Here the theory states that although the therapist is in control of the case, in practice the therapist may not use directive forms of therapy. In fact the technology of MRI is characterized by the use of the one-down position or by the indirect, paradoxical approach:

> Paradox plays as important a role in problem resolution as it plays in problem formation. . . . Symptom prescription--or, in the wider, non-clinical sense, second-order change through paradox--is undoubtedly the most powerful and most elegant form of problem resolution known to us. (Watzlawick et al., 1974, pp. 113-114)

The methodology or interventions used by The Brief Therapy Project are often geared to the blocking of the left hemisphere, or rational side, of the brain (Watzlawick, 1978). They are designed to bring about second-order change which results from a shift of levels. The therapist operates to redefine the problem in such a

way that the client can move outside of the context or to a different level of meaning and therefore to change (Watzlawick et al., 1974).

In theory, the therapist must have a variety of intervention skills available. Although the therapist is active and controls the sessions, in practice, the therapist may take the one-down position as a way to offer the least resistance to change (Fisch et al., 1982, p. 35). He or she may also deny competence and move to a position of helplessness or uncertainty (p. 171). An important point here is that the therapist has a wide range of skills available and actively chooses to use those skills which give the illusion of his or her not having control.

Jay Haley and Cloe Madanes: Problem-solving or Strategic Therapy; Therapy for Disturbed Young People

Jay Haley worked with MRI and Minuchin, but categorizes himself as a strategic family therapist because of the carefully planned strategies involved in his work. In essence he and Cloe Madanes are the bridge between Structural Therapy and MRI and depend heavily on many of the interventions developed by MRI, often operating from the theory developed by the Bateson Project (Hoffman, 1981). They have a strong emphasis on hierarchy within family structure and within the clinical context. This is

especially true in Haley's Leaving Home model, where he outlines a model for working with disturbed young people (Haley, 1980).

> When no one takes charge or assumes responsibility, it means that an organization is in confusion with no hierarchy making clear lines of authority. When the hierarchy of an organization is in confusion, mad and eccentric behavior occurs and is adaptive. . . . To correct the mad behavior, it is necessary to correct the hierarchy of the organization so that the eccentric behavior is not necessary or appropriate. (Haley, 1980, p. 44)

To best facilitate the change to appropriate hierarchy the relationship between therapist and supervisor must be clear. The supervisor is in charge of the therapist who is in charge of the family (Haley, 1980). All interventions come from the stance that the therapist is the one who is guiding the therapy (Haley, 1976).

Madanes' strategic therapy (Madanes, 1981) also emphasizes hierarchy and the importance of the therapist's leadership position in the therapy context. The metaphoric or analogic message of a symptom is stressed as important as well as the simultaneous, incongruent hierarchies which arise in families when symptoms are present. (An incongruent hierarchy exists for example when a symptom appears to make a person helpless but having the symptom gives the person power in the system.) A variety of direct and indirect techniques are suggested as means to intervene in the patterns of symptomotology. Working in well-defined stages, the therapist uses directives to move

the Identified Patient out of a dysfunctional triangle and to secure the parents in their position as executives of the family system. Within a couple the hierarchical incongruence, which a symptom expresses, must be resolved.

The therapist is in charge of treatment and takes an active role (Madanes, 1981, p. 19). Joining is stressed to make the family feel comfortable (Haley, 1976) but, "self-disclosure for its own sake is avoided, except perhaps as a vehicle for either joining or shifting power" (Stanton, 1981, p. 371).

In general the methodology used is very directive with the goal being the reorganization of hierarchy and the dispersal of the symptom which acted as a metaphor for the inappropriate interactions of the system (Madanes, 1981; Haley, 1976). "Directives may be straightforward or paradoxical" (Madanes, 1981, p. 24), direct or indirect. Tasks may be given or such indirect exercises as pretending or directing the parents to direct the child to have the problem.

Haley's Leaving Home (1980) outlines a very specific method for treating disturbed young people which is different from the more general problem-solving approach. Here the therapist comes from a position of power to move the parents to take control of their disturbed child. He draws on all his authority and power to do this quickly and efficiently so that the young person can get on with

his or her life in a socially appropriate manner. Paradox is not used; only direct intense interventions are made, most often with a supervisor behind the one-way mirror (Haley, 1980).

The Milan Group: Long "Brief" Therapy; Strategic or Family Systems Therapy

This model of therapy, which was developed by Mara Selvini Palazzoli and her colleagues at the Institute for Family Study in Milan, has as its goal the determination of family rules and the countering of those rules so as to free the family from patterns of interaction which require a symptomatic member (Selvini Palazzoli, et al., 1980, p. 4). The family is viewed as a rule-governed system where, "None of the members of the circuit have unidirectional power over the whole, although the behavior of any one of the members of the family inevitably influences the behavior of others" (Selvini Palazzoli et al., 1980, p. 5).

The team of four psychiatrists work together from a neutral position to discover at least one rule or the rule about the rules because, "Our results have indicated when we are able to discover and change one fundamental rule, pathological behavior quickly disappears" (Selvini Palazzoli et al., 1980, p. 4). The team works with a one-way mirror to allow at least one therapist to be in the room and the others to be able to observe outside the emo-

tional field. They develop lines of questioning which are circular in nature, and powerful in influencing the patterns of interaction in the family. Interventions are designed from information gathered from the family in such a way that they are met with the least resistance possible and will counter the family rules while also joining with the family game (Selvini Palazzoli et al., 1980).

The Milan Group sees the development of methodology as something which can be taught and is not dependent upon the therapist's "intangible, personal qualities of 'intuition,' 'charisma,' 'concern,' etc." (Selvini Palazzoli et al., 1980), which are often attributed to Salvador Minuchin or Jay Haley (Hoffman, 1981).

Before a session the team develops a hypothesis which is systemic in nature thereby including all relational aspects of the system. The Milan Group sees this hypothesis as having an influencing impact because the therapist is taking an active role and is not simply accepting the family's linear definition of the problem (Selvini Palazzoli et al., 1980). The therapist is influencing the family in two ways simultaneously, indirectly and actively as experts. The therapists, as experts, are devising a hypothesis and plan which shapes and co-evolves new meanings with the family. This is somewhat similar to The Brief Therapy Project or Haley/Madanes in that the thera-

pist is expert and as the expert chooses a way of working which is not direct.

In order to gather information to test the developed hypothesis, the therapist uses a method of asking questions where family members are asked to comment on the relationships of others. This is also an indirect means of influence in that the questions themselves as well as the answers may begin breaking down rules and certain patterns of interaction. The manner in which the therapist asks the questions should be in such a way that he or she allies with each family member and thereby appears neutral (Selvini Palazzoli et al., 1980).

The therapist is in charge of the session, although the therapist does not use herself or himself in the manner of the structural family therapists. This is confirmed in Paradox and Counterparadox, where simply the act of delivering what might be an indirect intervention is viewed as a metacommunication to the family that the therapist is in a position of leadership (Selvini Palazzoli et al., 1978).

Although the Milan Group stresses the importance of theory and the correct assessment of the system, a great amount of space in their writing is dedicated to specific categories of intervention. The therapist is in charge, but she or he may act as if she or he is not by declaring an inability to help (Selvini Palazzoli et al.,

1978). This is a tactic which may challenge the family rules. The therapist may also give directives, prescribing tasks or a set of behaviors to be carried out between sessions. This is more like the Haley/Madanes direct forms of influence.

Paradox, a form of indirect influence, is often employed by the Milan Group. In some forms of paradox, the therapist joins the system, not by social banter, but by acknowledging the importance of each family member, their mutual helpfulness, and paradoxically, the necessity of the symptom (Selvini Palazzoli et al., 1978). This form of joining and intervening focuses on challenging family rules rather than motivating individuals by having a relationship with them.

Summary. This section provided a general overview of the role of the family therapist within the four models. For the purposes of this study it is important to note what the four models have in common:

1) The need for the therapist to be in charge of the therapy;

2) The need for the therapist to be able to be active and directive;

3) The need for the therapist to use paradoxical and other indirect techniques;

4) The need for the therapist to have a wide range of behaviors from which to choose; and

5) The need for the therapist to operate in such a way in the session that the family can change to healthy behavior.

Family Therapy Process: Microskills of the Therapist

Given the vast array of theories in the field, what do family therapists do? There is little empirical research in this area but a few theoretical pieces have been written. Pinsof (1981) outlines three factors which he thinks explain the "dearth of family therapy process research and the developmental primitiveness of the field" (p. 701).

1) Family therapy constitutes a complex form of social intervention which is very difficult to analyze;

2) There is a "lack of adequate microtherapy theory" in the field of family therapy," which brings the theory from a high level of abstraction to a lower level operationalizable set of constructs" (p. 701);

3) The psychotherapy research field up to this point has been centered on individual therapy; therefore, there is little research theory yet evolved for family therapy process research.

In 1973, Cleghorn and Levin made one of the first attempts at developing behavioral objectives for the family therapist. They categorized the skills as 1) per-

ceptual, or the ability to see relational interactions, 2) conceptual or the ability to formulate rules and hypotheses of familial interaction, and what therapist behaviors are required for change, and 3) executive or having the means available to "influence the family to demonstrate the way it functions". . . and its "sequences of transactions so as to alter the way it functions" (p. 441).

The authors also divided the objectives into basic, advanced, and experienced. They proposed that therapists with basic skills can work with families who are experiencing common difficulties of transitions rather than being stuck in long-term dysfunctional patterns; advanced therapists have acquired skills which permit them to intervene in more rigid, chronic families, while the experienced therapist has gained enough skills and experience to operate on many levels at once, rapidly and comfortably conceptualizing in terms of process and theory and moving quickly to executing interventions.

Because it is difficult to separate perceptual and conceptual skills, they will be grouped together in the discussion.

Examples of basic perceptual and conceptual skills which Cleghorn and Levin developed are: "Describe a family systematically; include assessment of current problem," or "Recognize and describe the experience of being

taken into the family system." Corresponding basic executive skills would be: "Establish therapeutic control," and "Extricate oneself from the family system." (Cleghorn & Levin, 1973, p. 443)

In the advanced skill area a perceptual/conceptual skill is to "Recognize that change in a family is more threatening than recognition of a problem" (Cleghorn & Levin, 1973, p. 442). It is coupled with the executive skill: "Take control of maladaptive transactions by: a) stopping a sequence and labeling the process; b) making confrontations in the context of support" (p. 442).

One concept emphasized by Cleghorn and Levin which is not highlighted by the structural and strategic therapists reviewed earlier is that the therapist must pay close attention to his or her personal responses to aid in formulating interpretations and interventions for the family. The therapist and family make a new unit where the therapist's responses become an integral part of the unit.

Tomm and Wright (1979) have developed an even more comprehensive outline of family therapy skills for systems-oriented trainees. Their model was not drawn from any one theory but "has evolved by assimilating many concepts and techniques of other therapists and approaches to therapy" (p. 228).

The authors discerned four major functions of the family therapist: 1) engagement or joining the family and establishing a "meaningful working relationship" (p. 228); 2) problem identification both initially and as an ongoing part of therapy; 3) change facilitation; and 4) termination. In carrying out these larger functions or "macroscopic" skills, the therapist uses a set of "microscopic skills" (p. 228), the categories of which were taken from Cleghorn and Levin (1973): the perceptual/conceptual skills which take place in her or his head and executive skills, actual behavioral and affective responses. For each set of perceptual/conceptual skills within the four areas of functioning, there is a corresponding set of executive skills. The authors understood fully the complexity of the family therapy process and the need for flexibility in using their model.

An example of Tomm and Wright's model follows:(p. 230)

Under the function of engagement is listed the macroskill "Establish Positive Relationships." One perceptual/conceptual skill listed states:

> Realize that by deliberately acknowledging each family member, engagement with the whole system is enhanced.

The corresponding executive skill is:

> Give recognition and status to all family members

through some direct interaction with each one.

There are two studies which have developed skill inventories pertaining to the structural and strategic family therapies, Roberts (1981) and Falicov, Constantine, and Breunlin (1981). Roberts developed a set of 32 broad skill areas some of which were based on Tomm and Wright (1979) and many of which were based on her own detailed analysis of the four family therapy models discussed earlier. She used these skill areas as part of her instrumentation in assessing skill acquisition within two different forms of live supervision. Some examples she developed include: "Seek out, understand, and use family rules and myths in treatment" (p. 287), and "Understand and operationalize a range of structural interventions such as boundary marking, restructuring moves, unbalancing, and clarifying hierarchy" (p. 286). These were broad skills which specifically reflect structural, strategic, and systemic family therapies.

Falicov, Constantine, and Breunlin (1981) have developed a set of micro structural/strategic family therapy micro-skills, using Tomm and Wright (1979) and Cleghorn and Levin (1973) as models. In their work at the Institute for Juvenile Research in Chicago, they developed a family therapy training program which is based on training objectives. These objectives outlined observational,

conceptual, and therapeutic skills which corresponded closely to those categories developed by Tomm and Wright (1979). They ranged from joining to formation of paradoxical interventions. They also broke down skills into beginning, intermediate and advanced as did Cleghorn and Levin (1973).

Like Cleghorn and Levin (1973), Falicov et al. (1981) seemed to be especially sensitive to the individual trainee and the history and abilities he or she brings to training. They were aware of the challenges of practicing family therapy in various settings and were aware of the challenges and change the learning of the therapeutic techniques can bring. They commented that "To be effective trainees may need to modify, expand or inhibit their range of characteristic responses. Personal change occurs as a by-product of this process, rather than as a result of training objectives which require personal exploration and insight" (p. 502). This applied to men as well as women. In their model, time was devoted at the end of training to assessing both new skills and areas of personal change.

Only two other groups of researchers have used concrete skills in their studies.

In their construction of a family therapist rating scale, Piercy, Laird, and Mohammed (1983) developd a set of skill areas judged by experienced family therapists to be either essential or important for family therapists.

In the areas of structural and strategic family therapy, they have isolated such executive skills as "Lay down ground rules for the therapeutic process" (p. 57), "Reorders behavioral sequences," (p. 58), and "Employs paradoxical intention" (p. 58).

Doty (1983) developed a skill evaluation tool for trainers and supervisors. Some of the structural/strategic behaviors included were, "Prescribes an individual's own problematic behavior to gain paradoxical control of maladaptive interaction" (p. 3) and "Assigns realistic and clearly stated behavioral tasks for homework and seeks commitments to comply from the family" (p. 4).

All of the above studies built on one another to develop concrete skill areas which trainees must accomplish. They have thereby laid the groundwork for a synthesis of microskills of the four models of family systems theory.

Summary

This section has reviewed the literature on the development of operationalizable skills required of structural/strategic family therapists. It gives a general picture of the perceptual, conceptual, and executive skills expected of the therapist.

The next section is a discussion of the female family therapist's use of the skills and raises issues for further study.

Female Family Systems Therapists

As stated previously, several women have addressed the experience and behavior of female family systems therapists. All of them have emphasized the difficulties women trainees have in learning to take on the male stereotypic behavior which they feel is called for in providing good family treatment.

Caust et al. (1981) were one of the groups of authors who addressed the dilemmas of women training to become family therapists. They saw structural/strategic family therapy as offering women the opportunity to break away from stereotypic roles and become more active, directive, and instrumental in the therapy room. The authors claimed many women met difficulties because of sex-role stereotyping which has caused them to have a "relative lack of experience with leadership roles and the overt use of power" (p. 441).

> [T]he more active, orchestrative role of the therapist working in a family context is one of the salient attractive factors drawing female therapists to this modality. The structural/strategic family therapist takes risks, makes rapid decisions, assigns tasks to the familiy, moves family members around the room, and generally assumes control as an action-oriented director. (pp. 440-441)

The therapist, they said, must assume these new roles which are not only unusual for her but may be unexpected on the part of the family.

One problem area discussed was their view of women as having difficulty asserting their power in a straightforward manner as legitimate experts.

> Women tend to influence others more indirectly and to rely on their own personal resources, including attractiveness, kindness, empathy, and close interpersonal relationships for the exercise of power. Men have tended to use more direct influence attempts. (p. 441)

The context of training, in typically male-dominated organizations with male supervisors, may also work to reinforce learned sex roles. Similarly to Abramovitz and Abramovitz (1976), the authors warned that even when female trainees have women supervisors they may be overwhelmed by seeing a woman in a non-traditional, active role.

An aspect of some of the family therapies is the necessity of the therapist's manipulating boundaries within the family or between family and outside systems. Caust et al. (1981) noted the tendency for women's space to be easily invaded and their difficulty of maintaining their own personal boundaries. They thereby concluded that many women trainees would need to undo this tendency and learn new, more assertive skills in managing their own

and the family's boundaries as well as their boundaries with the family.

In addition to the more negative terms used in describing women, the authors pointed out some positives in terms of women's learned behavior. They thought many women can easily adapt to more indirect forms of interventions than men may be able to do, i.e., taking the one-down position or pretending to be confused in order to counter resistance. .

Sheely and Anderson (1982) addressed this quality of women saying that when the therapist is meeting resistance from a family, she must be able to assess the situation and take a 180° turn in her approach. What this involves is having a wide variety of skills available and being able to choose from them as the therapeutic context dictates. The woman family systems therapist must always be aware of how the wider social context dictates her behaviors when they may not be clinically sound. Sheely in her presentation also coined the phrase "de-skillment" meaning that women often experience their IQ dropping 30 points when they walk into a room of men or are confronted by a difficult family.

Reid (1983) coined a similar phrase, Dependent Mind Stuck (DMS) which she saw as an attitude women have learned "that fosters the continuation of undermining behaviors and leads to passivity, pleasing behavior, kind-

ness, and the avoidance of doing harm." She suggested that women family therapists must make a shift to a position as an active expert who has the appropriate skills to help a family. This would be a move away from the use of making a reference to her personal qualities or life in order to influence families to change. Reid stated that in live supervision a trainer can assume DMS is working if he or she hears the female trainee using a soft voice, notices "mushed" boundaries between her and the family, or sees the therapist fostering the family's dependence on her.

To reverse the problem of DMS, Reid suggested the supervisor frame the difficulty the trainee is experiencing as existing outside of herself, thereby making it part of the therapeutic system. She should then define new behaviors for the supervisee to try. She also suggested the use of Madanes' (1981) pretend strategies, having the trainee pretend to increase her range of behaviors, for example, in order to experience the power of new behavior within a different less threatening context.

As mentioned in the Caust et al. (1981) article, there are ways where female stereotypic behavior can be helpful to a female family systems therapist. Along with this, Tollers (1983) delivered a paper at the 1983 American Association for Marriage and Family Therapists entitled "Disadvantages and Advantages of Sex-Typing for

the Female Family Therapist, or How to Use External, Societal Expectations that Undermine Personal Authority to Your Own Clinical Advantage." She outlined several female stereotypic behaviors and the positive and negative values each might have for a woman.

One cultural bias Tollers cited is that women are not expected to be competent. On the negative side, nothing more than mediocrity will be expected from her; on the positive side, her unexpected competence can be powerful. Also, she felt it was easier for a woman than for a man to shift to a one-down position. Women are considered to be right-brained; therefore, systems or relational thinking may come naturally to them. According to Tollers, a difficulty is that women may not be challenged by supervisors to formulate clear theoretical ideas.

Reid (1983) who presented on the same panel with Tollers agreed with her that women need to fully develop conceptual skills as well as executive skills as outlined by Tomm and Wright (1979). She saw women as 'able to perceive what is happening in the session but less able to conceptualize it in terms of theory. Reid said that the woman therapist needs practice in being in charge of the session. Also, although most women may be naturals at relationship skills, many women may need assistance in keeping their boundaries so that they do not become just another family member.

Summary

All the writers in this section point to the assumption that women family systems therapists trainees are likely to:

1) have trouble carrying out those executive skills considered to be directive or instrumental;

2) join with the families to a degree which may not allow for the most efficient interventions;

3) be limited by the families' view of them as women;

4) be able to take the one-down position more easily than men;

5) have difficulty with conceptual skills;

6) have little trouble seeing relationships in families;

7) experience difficulty in keeping their own boundaries clear and in helping the family mark boundaries.

Synthesis

These last three sections on family therapy have summarized the literature on structural/strategic family systems theory from the point of view of the therapist's behavior. From the intersection of the literature on structural/strategic family therapists' behavior and the behavior of female family therapists, microskills can be identified which were considered by the authors to be

important for women practicing in the field. Some examples of these microskills are: 1) giving directives; 2) joining with the proper distance; 3) taking the one-down position; and 4) use of perceptual/conceptual skills. Now that these microskills have been identified empirical research must be conducted to test assumptions made by the authors on women's use of some of the skills.

It is important to bear in mind that in the midst of experiencing the mentioned difficulties, many women family systems therapists may work and train in male-dominated settings and also have fewer chances of obtaining academic and training positions. This fact may make it even more difficult for the women to take on a broader set of skills which might include stereotypically masculine behaviors. It may also be more difficult for men to develop more stereotypically feminine skills.

The next chapter outlines the method which was used to test if indeed men and women family therapists do work in the stereotypic ways suggested in the literature reviewed above.

C H A P T E R I I I

METHODOLOGY

Organization of the Chapter

This chapter describes the research method, including the design, subjects who were included in the study, the means of acquiring and selecting the sample, and the materials used. Finally a detailed outline of the research procedure is given.

Design

This investigation proposed to determine gender and experience-level differences among therapists practicing structural, strategic or systemic family therapy. Six different skill areas were tested in response to a case vignette: 1) perceptual/conceptual skills; 2) directiveness; 3) use of direct interventions; 4) use of indirect interventions; 5) attention to task; and 6) attention to relationship. In describing the design a rationale for the choice of skill categories is given. The literature is then used to develop hypotheses which were tested.

Rationale for categories to be tested

The literature review showed that information on

the differences between male and female family therapists is sparse. Similarly, the research on experienced and inexperienced therapists is not definitive. That literature most salient to the design of this study is briefly reiterated here to provide support for the selection of therapist skills used in this study.

There is some literature on female family systems therapists (Caust et al., 1981; Reid, 1983; McDaniel, 1983) which pertains for the most part to trainees. These authors hypothesize that women trainees have more difficulty than male trainees in executing active, instrumental microskills, and females have greater ease than men in performing more strategic, one-down behaviors. Implicit is the idea that women will tend to choose those behaviors which are expected of them and which therefore are more comfortable to perform, i.e., are more stereotypically feminine. Much of what these authors wrote is not based on empirical research, but rather is personal speculation based on experience.

The literature does not definitively show whether males and females are different in their cognitive skills or therapy behaviors, especially experienced males and females (e.g., Hill, 1975; Orlinsky & Howard, 1976). No study exists concerning differences in therapist behavior for experienced family therapists. Auerbach and Johnson (1977) in their review of the literature on individual

therapists' level of experience speculated that as therapists mature they become more confrontive and active. Their assertion is yet to be tested in a definitive manner. In her research on individual therapists, Hill (1975), using tapes from actual sessions, reported gender differences in several categories finding that inexperienced males were similar to experienced females in their level of activity and empathy. She also found therapists to be more directive with same-sex clients. This issue of directiveness and therapist activity versus a more emotional response to clients becomes important in the literature on women working with families. Rice et al. (1974) who used a self-report instrument also found differences between experienced and inexperienced therapists in their choice of therapeutic behaviors. This too was considered in this study.

Though the literature is slim, the few essay-type articles on women family therapists combined with the literature on family therapy microskills and research on individual therapy provide a source of some possible gender and experience differences. The review of the literature provided the foundation for the development of six skill categories which could be empirically tested in order to test for differences and similarities between female and male family systems therapists within three different experience levels. The skill categories are

defined below along with a brief rationale for their inclusion in the study.

1. Perceptual/conceptual skills were defined initially in Chapter I. They are those skills which enable the therapist to see interactions. They allow the therapist to make accurate observations and explain what is seen using theoretical material. This theoretical material may include actual formal theory, specific concepts, or the application of "previous learning to the specific therapeutic situation" (Tomm & Wright, 1981). Examples of these skills taken from the literature (Cleghorn & Levin, 1973; Falicov et al., 1981; Roberts, 1983) include the ability to identify channels of communication or non-verbal interactions and also the ability to use theory or specific concepts such as homeostasis, simultaneous incongruent hierarchies, alliances, and triangles in discussing a situation.

Duhl (Robbins, 1982) thinks women have a natural ability to see the world in terms of relationships but Reid (1983) states they are less able to conceptualize in terms of theory. They therefore may be able to see relationships but may not be able to discuss what they see using theoretical material.

2. Attention to client-therapist relationship is when a therapist shows interest in developing a therapeutic alliance or in having a personal connection with

the client family in order to move them toward positive growth. Minuchin's (1974) structural family therapy and Haley's Problem-Solving Therapy (1976) state the importance of forming a relationship with the client family while the Milan Group (Selvini Palazzoli, et al., 1978, 1980) stresses the formation of a neutral relationship or position. The MRI Group (Watzlawick et al., 1974) do not mention relationship explicitly.

Reid (1983) and McDaniel (1983) say the woman trainee has an innate ability to form relationships but stress that cultural expectations may cause her to become over-involved rather than appropriately involved. Reid especially warns against "mushed" boundaries and the woman's trying to please the family or fearing family dislike. These therapist responses could limit a therapist's ability to maneuver within the system.

3. Attention to task is when the therapist is concerned with problem resolution as demonstrated by attention to what the problem is and what actions need to be taken to solve it. A task-oriented therapist may view the family in terms of the problem rather than the people. In the most extreme instance the task-oriented therapist would see only patterns of interaction and would not involve her or himself in the emotional overlay or the context of family members' communication.

Caust et al. (1981) see this task-related aspect of therapy as stereotypically masculine. In their opinion it is one of the things that draws women therapists to family systems work, because it gives them the opportunity to move away from the stereotypically feminine relational aspects of the therapeutic work.

4. Directiveness. A directive therapist is one who takes active charge of the session in order to produce change. This therapist may use direct or indirect interventions but is the leader of the therapeutic system. A directive therapist takes the initiative, and is in charge of defining the therapeutic frame, leading the client and setting the boundaries of therapy. Stereotypically these tasks may seem more natural to men than to women. A non-directive therapist would be one who follows the family's lead going with them wherever they want to go.

Therapists use directives or directions along a continuum of intensity, for example, ranging from telling a family member to do a new behavior to allowing them to continue to make the decisions on who comes in.

5. Direct interventions are used by therapists when they wish to address a problem head-on. The goal in using this kind of intervention is for the family to change sequences of interactions by doing a task developed by the therapist (Madanes, 1981, p. 24). The task is

directly related to the presenting problem and its resolution, i.e., the digital level of the problem.

Examples of this therapist behavior are directing a family to enact a situation and then blocking a pattern which might appear, stopping one person from answering for another, giving a task which asks a distant parent to spend time with an identified patient, or directing the parents to come up with consequences for an adolescent's unacceptable behavior.

6. Indirect interventions are used when a therapist does not wish to address a problem head-on. The therapist may use less direct interventions which allow the family to evolve a solution on its own. This type of therapist behavior is least likely to arouse the family's natural resistance to change, because it often appears to be requiring that the family not change, or not change too fast. Indirect interventions may also redefine family difficulties as positive in some ways, thereby creating confusion but also possibly less resistance to change.

Examples of indirect interventions might be when the therapist pretends to take the one-down position, the use of circular questioning which asks family members to comment on others' relationships without the therapist actively intervening in that relationship, positive connotation, or prescribing the family to have the symptomatic behavior. A therapist may be very directive and in charge

of a case while using some indirect interventions, for example when a therapist clearly prescribes that a family continue to have a dysfunctional member.

Caust et al. (1981) state their perception that women would like to use direct interventions thereby moving away from the stereotypically feminine behavior of a less direct, more manipulative style. In contrast, Tollers (1983) stresses that women should use these stereotypes to their advantage. She sees women as good at some of the less direct interventions such as use of pretending or taking the one-down position. Sheely and Anderson (1982) stress the necessity of women having a range of clinical behaviors and being able to choose from direct and indirect methods as necessitated by the family. The overall gist of these papers is that women may have difficulty using the direct behaviors which may call for a more masculine style.

Six skill categories to be tested were developed from the literature. One other area which was tested was the issue of therapist self-perception in terms of their skills. The McMaster study (Woodward et al., 1981) had suggested that women underestimate their own abilities to help a family change. Therefore, a question was included to see where subjects rated themselves on a competency scale.

Hypotheses

From the categories outlined above several null hypotheses were developed. The null hypothesis was used because of the lack of prior clear empirical findings, the exploratory nature of this research, and for ease in statistical reporting. Here the word therapist refers to structural, strategic, or systemic family therapists. Bear in mind that the proposed lack of differences was tested between female and male therapists of three categories of years of experience.

1) Female and male structural, strategic and/or systemic family therapists within three difference levels of experience will show no significant difference in their use of perceptual/conceptual skills.

2) Female and male therapists within three different levels of experience will show no differences in their ratings of themselves on a range of attention to task vs. attention to client-therapist relationship.

3) Female and male therapists within three different levels of experience will show no significant differences in their ratings of use of indirect and direct interventions.

4) Female and male therapists within three different levels of experience will show no significant differences in their ratings of their directiveness.

And

5) Female and male therapists within three different levels of experience will show no differences in their self-ratings of competence as family therapists.

Sample

The subjects were 29 therapists (11 male and 18 female) who practiced structural, strategic, or systemic family therapy in community-based settings.

The sample was drawn from community-based mental health centers in Massachusetts. These were public agencies where outpatient mental health services are provided for a variety of people regardless of ability to pay. In these settings therapists normally spend 50% to 60% of their time providing direct clinical services to the clients on their caseloads.

The use of community-based mental health centers assured not only exposure to a range of patient problems, but also that therapists were trained in many different places rather than one or two training sites. This choice of setting allowed for greater generalizations in reporting the findings, but unfortunately limited the number of respondents due to the busy schedules and service-provision focus of the sample.

In order to contact the therapists, a list of mental health centers was made. Thirty-one executive directors were contacted first by letter (Appendix A) and

then by phone. Often a second contact person was designated by the executive director as the one who would be in charge of helping with the research.

Of the 31 agencies 22 agreed to cooperate. Altogether 145 questionnaires were mailed to the contact person except in two cases where the researcher was invited to come meet the staff, explain the research, and deliver the questionnaires in person. After seven days a follow-up postcard was sent as a reminder to return completed questionnaires as soon as possible.

Nineteen of the 22 agencies returned a total of 32 completed questionnaires. Reasons given by the contact person for low response included not enough time because of heavy job demands and difficulty and length of the questionnaire. Follow-up thank you letters were mailed to each responding agency after the final response deadline (Appendix A).

Once the responses were collected, only those therapists who identified themselves during the study as using one of the following theories as their primary theory base when doing family therapy were included in the data analysis: 1) Structural/Strategic (Minuchin, Haley, Madanes, MRI Brief Therapy, or Strategic Therapy) or 2) Systemic (the Milan Group's long brief or family systems, strategic model). Other choices were offered on the questionnaire in order to better disguise the theoretical

selection criterion of the research. Only three responses had to be discarded due to choice of theory, leaving 29 questionnaires to be analyzed.

As discussed earlier, the research was designed to study self-described behavioral choices to vignettes of male and female therapists of varying degrees of experience. Results obtained during the pilot led the raters to designate three categories of experience. This judgement was qualitative and based on complexity and integration of response. The categories were: 1) inexperienced therapists were those having fewer than two years of family therapy experience; 2) the next group was those therapists having 2-3 years of family therapy experience; and 3) the most experienced group had more than three years of family therapy experience.

The respondents fell into the six designated categories in the following way (see Table 1): 7 female therapists with more than three years of family therapy experience; 6 males with more than three years of family therapy experience; 7 females with 2-3 years of family therapy experience; 3 males with 2-3 years of family therapy experience; 4 females with fewer than two years of family therapy experience; and 2 males with fewer than two years of family therapy experience. Seven more females than males were in the final sample.

TABLE 1

DISTRIBUTION OF EXPERIENCE BY GENDER

Gender	Experience			
	Fewer than 2 years	2-3 years	More than 3 years	Total
Male	2	3	6	11
Female	4	7	7	18
Total	6	10	13	29

Instrumentation

Because of the newness of research in this area and the lack of appropriate instruments, a new questionnaire was developed and carefully pilot tested. This section gives the rationale for the use of a written questionnaire and describes in detail each part of the instrument.

Use of a written questionnaire

The written questionnaire was chosen for this study for several reasons. It allowed for use of a larger and broader sample than would have been possible with other means of collecting data, for example using videotape vignettes or actually observing therapy sessions. It allowed the researcher to ask open-ended questions intended to elicit perceptual/conceptual skills as well as therapist self-perception. It measured both speculated behavior and attitudes, skill choice, and thoughts about using certain skills.

This research was intended to be exploratory since it was devised from literature which for the most part consisted of the experiences or opinions of the authors. By giving subjects the opportunity to demonstrate perceptual/conceptual skills, choose executive skills, and discuss some of their views, this research was intended to add to that literature. Hopefully it may stimulate other

researchers to test these and other hypotheses drawn from that literature.

Structure of the questionnaire

The items on the instrument were developed by reviewing the skill categories and the hypotheses, and devising a series of questions which would address these skill areas. Below the construction of each section is explained in detail.

Part I: The Case Vignette. The case vignette was developed from a real family therapy situation familiar to the author, but was changed in order to disguise the family. The first pilot study contained five vignettes in order to determine which vignette stimulated the most useful answers. Unfortunately this made the pilot so long that respondents consistently did not complete Part I of the instrument. The most thorough responses were obtained on the first two vignettes so they were used in the last two pilots. Since the questionnaire was still too long, only one vignette was used for the actual research (see Appendix B).

In Part I, the subject was asked to read the vignette and answer four questions which reflected the skill categories. The first question was on assessment, which allowed subjects to demonstrate perceptual/conceptual and assessment skills. Question 2a asked for a

self-rating on attention to task and attention to relationship, 2b asked the subject to give a rationale for her or his rating and, 2c asked for a demonstration of these skills by asking the subject to give examples of interventions he or she may make in the situation. Questions 3 and 4 gave the opportunity for subjects to rate themselves on and give examples of directiveness and direct and indirect interventions they may have used with the particular case.

Part II: Further Questions. The second part of the instrument consisted of one closed question and five open-ended questions. The closed question tested hypothesis 6, asking the subject to rate how competent she or he felt as a family therapist.

The first open-ended question gave the subjects a chance to outline skills which they felt they would like to have. The answers were used to see which skills men or women, experienced or inexperienced, chose. The second two questions gave the subjects a chance to report how they think families view them and what kinds of image they would like to have. These open-ended questions were used as another way to gather data on skill choices and to enhance findings from questions on the vignette regarding gender and experience differences. The last two questions asked respondents to report how they think their supervisor views them and how they would like to be viewed. As

in the other questions on this part, the researcher looked for trends in these responses which could supplement other findings.

Part III: Demographics. Demographic information gathered included: theory base, gender, highest degree, years of clinical practice, years of family therapy practice, age, and place of training. This information was helpful in establishing not only experience level and gender but also other variables which may influence responses. Rice et al. (1974) found age to be significant in therapists' use of a wider variety of behaviors. Highest degree attained was asked as a means of determining any differences among groups with different professional training. The theory base was attained to eliminate those not using the models selected for inclusion in the study. The answers to that question combined with the responses to Part I could also be used at a later time as a separate study to ascertain differences between those using the structural/strategic or systemic models and those using other forms of family therapy.

Procedure

Pilot study

Three pilot studies were used to test the content of the instrument and the coding system. Practicing structural, strategic, or systemic family therapists who were

known to the researcher but who were not familiar witwh the research made up the pilot respondents.

After the first pilot (n = 10), the questions following the vignettes were changed because they were not yielding enough information. The second pilot (n = 6) allowed the coding system to be tentatively validated and showed the necessity of refining certain questions, eliminating others, and changing the order in which some items were asked.

The final pilot contained two case vignettes and the other two complete parts, containing general questions and demographics.

The final pilot was used to refine a coding system, train the coders, and to determine an observable interrater reliability. The coders rated the final pilot instruments, but interrater reliability was not formally measured until the final study.

Final study

The procedure for contacting the subjects was described earlier in the description of the sample. This section will discuss the directions given to each individual subject.

Each subject received an envelope containing a questionnaire and a letter describing the research (Appendix C). The letter assured each respondent of her or his

anonymity. It asked for the respondent's signature granting permission to use responses and outlined a method for obtaining results.

Once each questionnaire was received, it was labeled with a number. The permission slips and requests for a summary were separated and placed in separate envelopes. At no time was the researcher or the raters aware of who a respondent was.

Analysis of Data

The pilot was used to develop an initial coding system which was later revised after the final pilot and again when responses were collected. After the coding system was created, interrater reliability was tested. A detailed description of the analysis system is given below.

Development of a rating system

This section will present the coding system, the rationale for the system and the means of measuring interrater reliability. The purposes of the coding system were to: 1) determine interrater reliability; 2) determine the raters' opinion of the accuracy of respondent self-ratings; 3) provide a means to handle qualitative material in a quantitative manner; and 4) provide a means to analyze the tone, style, and qualitative aspects of the open-

ended responses. The coding and analysis of each section of the questionnaire including interrater reliability will be discussed separately.

Part I. Three distinct but interrelated rating methods were used to analyze responses in Part I, the case vignette. Given the nature of the questions, the coding system for question 1 was different from the coding system for questions 2 through 4. (See Appendix D for a copy of the coding schedules.) The rating system for each question is explained. Then, after discussing each question, the means of obtaining intercoder reliability plus the results of the intercoder tests is given. In all areas the coding system was developed after the second pilot and refined using the third pilot and the final responses.

Question 1. There were three separate means of analysis. First, a scale was developed asking the rater to decide how much the respondent relied on formal theory as opposed to past experiences in presenting an assessment. This was a 5-point scale. It was thought initially that it would be quite evident as to which option along the scale was used, but as described later, the definitions were difficult and the ratings were inconsistent.

The second type of rating system was a coding system which was developed to attempt to categorize free-flowing responses to the assessment question. The purpose was to organize symbolic phenomena, i.e. a written state-

ment, into units or categories which could then be treated quantitatively (Crittendon, 1971). The entire response to question 1 was considered to be the coding unit, from which categories were drawn (see Appendix D). Using the entire range of responses in both the pilots and the final study, and then placing those in common together, a total of 10 categories were developed. Each complete thought within the coding unit was then coded in terms of the pre-established 10 categories. The end result was a frequency count of the categories within the coding unit. This type of coding allowed the researcher to use appropriate statistical manipulations to establish trends across categories for sex and experience within each coding unit.

The third type of analysis was a qualitative analysis in which the tone, quality, and style of response was analyzed. The questionnaires were sorted into the six groupings based on gender and experience level in order for the raters to get an overall sense of a complete category. Without knowing with which group they were working, three raters, one male and two female experienced family systems therapists, then read all the responses to question 1 and drew out trends within groups. Once each group was analyzed, the groups were compared and contrasted. Examples were used by raters and in the discussion of findings to support conclusions.

Selection of this last type of analysis had several bases. Family therapists typically work in teams building on each others' hypotheses. Because this is family therapy research it was natural to use some family therapy methodology to analyze data. Also the very important aspects of tone and quality of response can be lost in the more sterile individual coding of responses.

In discussing findings all results of the different methods of analysis were reported and then synthesized to give a well-integrated and well-supported final analysis.

Questions 2 through 4. These were analyzed in a similar way to question 1. In section (a) of each question, the respondent was asked to rate her or himself on a scale. The rater was then asked to read all of that question response and then rate the respondent on that same scale. The purpose was to add an external perspective to compare with respondents' self-perception. Unfortunately there was no way to prevent raters from knowing the self-rating so this may have biased coder ratings. Pearson product-moment coefficient correlation was used to test for significant differences between respondent and rater choice and also between different respondent groups' choices.

Sections (b) and (c) of questions 2-4 were categorized using the same quantitative coding method as was

used for question 1. (See Appendix D.) The total response to each section was the coding unit from which categories were developed. The rater placed each complete thought in a category and frequency counts were obtained.

After all individual coding was completed for questions 2 through 4, the team worked in the manner described for question 1 to determine trends in response, tone, and quality. Examples were used to support the qualitative findings.

For each of the four questions in Part I, cross-tabulations were used to determine differences between males and females and differences among experience levels. Chi-square (for $N>25$) or Fisher exact test (for $N<25$) were used to test for significance. Because of the small sample size, however, caution was used in not accepting the null hypothesis.

Part II. The closed question, which asked for a self-rating of competency on a 5-point scale, was coded along the continuum of responses. Once again a Pearson's product-moment correlation coefficient was used to determine significant differences among groups. The open-ended questions in Part II were codified using the categories developed as in the content analysis of Part I. Cross-tabulations to determine significant relationships of competency ratings among the groups as well as descriptive analysis were completed.

Part III. Relationships between the demographic variables and the items on the subscales and open-ended questions were examined by cross-tabulations. Significant relationships determined by chi-square or Fisher exact test were highlighted, and a detailed demographic description of the sample was made.

Interrater reliability. To test interrater reliability five questionnaires were selected at random and one male and one female experienced family systems therapist, each of whom were final judges, coded those five questionnaires. Pearson's product-moment correlation coefficient was used to test interrater reliability on each of the rater scales in questions 1 through 4 of Part I. The coefficient for all 4 scales was .55, which was far from significant, therefore showing no interrater reliability. Because the scale for question 1 appeared to have the worst interrater reliability, the correlation was determined for that scale alone. It was -.06 which means no correlation existed on that scale. In order to test for interrater reliability on the other scales altogether, a coefficient for the scales on questions 2 through 4 was determined. It was .903 which is well within the acceptable range for interrater reliability. Because of these results the scale in question 1 was discarded for purposes of reporting findings.

Interrater reliability was next determined for the coding of the open-ended sections of questions 1 through 4 in Part I and questions 6 through 10 in Part II. As stated above, each of the five randomly drawn questionnaires were coded by the two raters. Once coding was completed the coding differences for each question were determined. Categorization of responses for the two raters were identical 97 percent of the time.

Because interrater reliability was within the significant range, the remainder of the questionnaires were each coded by only one rater. In all, 10 randomly assigned questionnaires were coded by the male and 19 by the female.

Summary

This chapter presented six null hypotheses relating to the interaction of gender and experience within skill categories related to structural, strategic, and systemic family therapy theory. A design for an empirical study to test these hypotheses was then presented. The sample, instrument, and procedures were outlined as well as the design of the instrument. The analysis of data was also overviewed.

C H A P T E R I V

RESULTS AND DISCUSSION

Organization of the Chapter

The purpose of this chapter is to present the findings and discussion of the research. After presenting data and discussion on the subjects, each hypothesis is discussed individually as described in Chapter III. Three types of data are provided for the hypotheses: scale analyses, category frequency results, and qualitative findings.

First the statistical findings related to the individual hypothesis will be reported. In order to decide which coding categories should be highlighted, a frequency count was obtained. Where there was a high frequency or where the literature might suggest significance, cross-tabulations with gender and experience level were done. If appropriate statistical tests suggested trends or significance they are highlighted in the analysis. For the scales, a cross-tabulation and significance testing were also done. Next the raters' qualitative trends are reported using excerpts from the responses to support this part of the findings. Once the findings are reported, there is a discussion of results.

Questions 6 through 10 in Part II are not related to the hypotheses but their findings enhanced the results of the other questions. Once the results and discussion

of Part I are complete, the results and discussion of Part II are presented.

Results and Discussion

The sample

Data on the sample are presented in two ways. First each demographic variable is considered separately. Then the interaction of gender and experience level with the variable is discussed.

The sample consisted of 29 respondents, 18 female and 11 male who were between the ages of 25 and 62. The mean age was 35.8 and the mode was 33, which represented four respondents (see Table 2).

The majority of respondents (21) had master's degrees, 4 had the doctorate, and 4 had bachelor's degrees (see Table 3). The mean year of graduation was 1977, the mode 1980, with the range being 1964 to 1985. Fewer than one-half (44.8%) of the respondents received their family therapy training at a university or college graduate program (see Table 4); 34.5% received their training on the job; 17.2% received it at a family therapy training institute; and 3.4% received training through attending workshops. Eighteen respondents marked themselves as structural/strategic and 11 as systemic (see Table 5).

The majority of respondents (72.4%) had over 3 years of general therapy experience; 13.8% had 2 to 3

TABLE 2

AGE

Career and Experience Level	Age 21-25	26-30	31-35	36-40	41+	Total
M, >3 yrs.	0	1	3	1	1	6
F, >3 yrs.	0	0	3	0	4	7
M, 2-3 yrs.	0	1	1	0	1	3
F, 2-3 yrs.	1	1	4	1	0	7
M, <2 yrs.	1	0	0	1	0	2
F, <2 yrs.	0	2	0	2	0	4
Total	2	5	11	5	6	29
Total M	1	2	4	2	2	11
Total F	1	3	7	3	4	18

M = Male; F = Female
>3 = more than 3 years family therapy experience
2-3 = 2 to 3 years family therapy experience
<2 = fewer than 2 years family therapy experience

TABLE 3

HIGHEST DEGREE ATTAINED

Career and Experience Level	Degree Doctorate	Master's	Bachelor's	Total
M, >3 yrs.	2	4	0	6
F, >3 yrs.	1	6	0	7
M, 2-3 yrs.	1	2	0	3
F, 2-3 yrs.	0	6	1	7
M, <2 yrs.	0	2	0	2
F, <2 yrs.	0	1	3	4
Total	4	21	4	29
Total M	3	8	0	11
Total F	1	13	4	18

TABLE 4

LOCATION OF FAMILY THERAPY TRAINING

Career and Experience Level	Location: University or other college graduate program	Family Therapy Training Institute	On-the-job Training	Work-shops	Total
M, >3 yrs.	2	2	2	0	6
F, >3 yrs.	1	3	3	0	7
M, 2-3 yrs.	3	0	0	0	3
F, 2-3 yrs.	3	0	3	1	7
M, <2 yrs.	1	0	1	0	2
F, <2 yrs.	3	0	1	0	4
Total	13	5	10	1	29
Total M	6	2	3	0	11
Total F	7	3	7	1	18

TABLE 5

LENGTH OF GENERAL CLINICAL PRACTICE

Gender and Experience Level	No. of Years of General Clinical Practice			
	>3	2-3	<2	Total
M, >3 yrs.	6	0	0	6
F, >3 yrs.	7	0	0	7
M, 2-3 yrs.	2	1	0	3
F, 2-3 yrs.	4	3	0	7
M, <2 yrs.	1	0	1	2
F, <2 yrs.	1	0	3	4
Total	21	4	4	29
Total M	9	1	1	11
Total F	12	3	3	18

years of experience and an equal number had less than 2 years of experience (see Table 6). However, the number of years of family therapy experience was different with only 44.7% having more than 3 years, 34.5% having 2 to 3 years, and 20.7% having fewer than 2 years of experience.

The tables not only show the general statistics cited above, but also show how these demographic variables break down according to gender and levels of family therapy experience.

Age. (See Table 2.) As stated earlier, the mean age was 35.8. Considering the difference in numbers of male and female respondents, the distribution of age for each gender was fairly similar. The oldest person was a woman age 62. The two youngest were a male and a female.

Degree. (See Table 3.) Of those four respondents who held the doctorate, only one was a woman and all four respondents who held a bachelor's degree were women, one having 2-3 years of experience in family therapy. No men held below a master's degree.

Family therapy training. (See Table 4.) More than half of the men (6 = 54%) but only 38% of the women received training at a university or other college graduate program. An equal number of women were trained on the job (38%) as were trained at a university or other college graduate program, while only 27% of men were trained on

TABLE 6

THEORY BASE PREFERENCE

Career and Experience Level	Theory Base		
	Structural/Strategic	Systemic	Total
M, >3 yrs.	2	4	6
F, >3 yrs.	6	1	7
M, 2-3 yrs.	2	1	3
F, 2-3 yrs.	3	4	7
M, <2 yrs.	2	0	2
F, <2 yrs.	3	1	4
Total	18	11	29
Total M	6	5	11
Total F	12	6	18

the job. Of those with the most experience, only 3 out of 13 (23%) were trained at a university or other graduate school. The rest received instruction at either a training institute or on the job. All the mid-level males received training at a university or other college graduate program, but an equal number of women on that level learned on the job or at the university or other college graduate program.

General clinical experience. (See Table 5.) Six of the respondents with 2-3 years of family therapy experience had more than 3 years of therapy experience, 2 out of 3 males and 4 out of 7 females. One of 2 males and 1 of 3 females with fewer than two years of family therapy experience had more than 3 years of other therapy experience. The males were the most experienced group with 9(81%) having more than 3 years of experience. The 12 women with more than 3 years of experience represent only 66% of the women.

Theory base. Table 6 shows that of those therapists with more than three years of experience, 4(67%) males and 1(14%) female chose systemic theory and 6(86%) females and only 2(33%) males chose structural/strategic theory. This difference between genders in their choice of theory is statistically significant: a = .08 on Fisher's exact test. In other words, women chose structural/strategic theory over systemic theory significantly more often

than men and men chose systemic over the other significantly more often than women. For those with 2-3 years of experience, there was little difference in the division but for respondents with fewer than two years of experience, all but one chose structural/strategic, the one being a female.

The males divided evenly between structural/strategic and systemic but the females had twice as many structural/strategic therapists than systemic therapists. This is discussed more in the next section.

Discussion of demographics. As stated above, this group of therapists was characterized by more educated and clinically experienced men than women and by more men who were trained in doctoral programs, graduate programs, or training institutes. These findings are similar to those of Gurman and Kniskern (1978) who critiqued the McMaster study (Woodward et al., 1981) saying results were skewed by the fact that the men had more education and were in more socially accepted fields, psychiatry and psychology, than were the women who were in social work and nursing. It also reflects the findings of Russo and Vandenbos (1981) who found women with high degrees to be underrepresented in mental health agencies.

In this study the fact that a higher percentage of men had more formal training than women and that some women have only bachelor's degrees may be important when

looking at perceptual/conceptual skills. The more formal training consists of more theoretical training and probably the practice of using theory to explain interactions in a family. The on-the-job training may tend to bypass theory in favor of use or development of interventions. It is also interesting that women with bachelor's degrees are practicing, especially in a system which requires master's degrees plus two years of experience in order to collect third party payment. It is unclear how this has occurred or what it means in terms of hiring practices and training of women.

In the question on theory base, a significant difference was found between males and females in the most experienced category in their choice of theory. Women chose structural/strategic theory much more often than men. Caust et al. (1981) had postulated that women tended to be drawn to structural therapy because of the opportunity to use masculine types of behaviors such as directiveness and taking charge of a situation. Among this group of women, these characteristics of assertiveness and taking charge were clear. Their written assessments tended to use theory which stressed terms such as metaphor, loyalty, and symptom function, which come from strategic or Milan-style systemic assessment theories. It is unclear therefore if the women saw themselves as struc-

tural, strategic, or a combination. A more detailed breakdown of theory choice would have shown this.

Hypothesis 1: Female and male structural, strategic and/or systemic family therapists within three different levels of experience will show no significant difference in their use of perceptual/conceptual skills.

Although all of the responses on the questionnaire involved the respondents' use of perceptual/conceptual skills, question 1, which corresponds to hypothesis 1, explicitly asked for assessment and therefore the use of these skills.

Statistical findings. Each complete thought or phrase was categorized by a coder into one of the 10 categories (see Appendix D). The frequencies for the categories were then determined. The highest frequencies are reported here. These two categories are central theoretical features in the family systems theory. The large showing reflects a good sense of systems theory on the part of the respondents. In the coding of the assessments of the case vignette, 22 or 76% of the respondents were categorized as having discussed relationships among family members (triangles, dyads) more than 50% in each of the six gender/experience level categories. The category of discussion of the function of the IP's (Identified Patient) symptom in the family system was coded for 62%

(18) of the cases. In general, mention of this was distributed evenly between males and females. However, in the cases of those with more than 3 years of experience, 85% of the women (6 out of 7) and only 50% of the men (3 out of 6) were placed in this category. Although this is not statistically significant, it shows a slight trend (a = .23 on Fisher's exact test) which suggests that women at this level may focus on the person with the problem more often than their male counterparts.

There were no other statistical trends as shown by the Fisher's exact test or chi-square. Findings of tone, style, and quality were addressed by the team of raters. These team results are presented and discussed below.

Qualitative findings. In developing these themes, responses of each subject group were studied; therefore, patterns within each category of gender/experience level were identified as well as patterns across categories.

Therapists with more than three years experience. The women with more than three years of experience were viewed by the raters as delivering their assessments in a free-flowing narrative style. They appeared to be organizing their thoughts right on the page. However, their thinking of the case in systems terms or in other terms which helped them organize the material in a meaningful way was clear to the raters.

Said one respondent, "Out of a sense of loyalty to her father, out of a sense of responsibility to her family as the oldest legitimate child, in a spirit of profound love, compassion, and caring, Daughter A has appointed herself the pain bearer in the family."

This was not only considered free-flowing but also dramatic. It started by focusing on the IP (Identified Patient) as did many of these responses by women in this category, and it stressed family loyalty and sacrifice as did the other responses; e.g., "Daughter is . . . being loyal to parents thru [sic] her somatic symptoms." These respondents focused on the IP and the function or metaphor of her symptom in the system.

This group was not seen by the raters as using a particular theoretical model but more of a blend of models including some intrapsychic ones, for example, "The daughter's symptoms may represent an attempt to join the parents in illness; or it may represent an outcry of muted rage." They were perceived by the coders to speak from experience rather than a clear model. This could be a reflection of their training on-the-job which may have been more application-based rather than grounded in a particular theory. Still, the coders' analysis of assessments showed a good grounding in systems theory and organization and thinking which leads to action. These women were seen to have a strong grasp of what was happening in

the clinical case. Their perceptual/conceptual skills were well-developed. Their way of expressing them was viewed as organized differently from their male counterparts as is seen below.

In comparison to the experienced women, the experienced men were also viewed as giving very emphatic responses to question 1. They appeared to be very task-oriented in their approach to the assessment. Although they too focused on the IP, they were seen as giving less dramatic, more matter-of-fact assessments than the women in this experience level. Many simply made lists in a very detached, objective way, as if, according to the raters, they had a theoretical and experiential checklist from which they drew their assessments.

An example:

> Dysfunctional triangulation between Mo, Fa, and Dau. Fa and Dau in overclose position.
>
> Marital conflicts submerged, both Mo & Fa suicidal transmission of anxiety throughout system.
>
> Return of out of wedlock child threatens Dau's position, possibly experienced by her as dislocation.
>
> Family of origin conflicts - needs more info.
>
> More of same wrong solution behavior
>
> Hierarchy diffuse

This group was seen as more homogeneous than the experienced women. They tended to use structural termi-

nology, for example, discussing enmeshment or overinvolvement rather than loyalty. Another respondent said, "Daughter is triangulated into marital relationship." Still another said, "This family . . . seem enmeshed."

The raters had a strong sense of what these men would actually do in the room. This came from their integration of theory and case specific material which was similar to the women in this group. An example of where theory and case specific material are well integrated is the following:

> The pending return to the family of the 14-year-old son will require realignment of established coalitions.

Therapists with 2-3 years experience. As a whole group, those therapists with 2-3 years of experience gave much less complex assessments than the more experienced respondents. Because of the use of many conditional words, they were also rated as more hesitant as if they had to check with a supervisor before being sure of what to do next. They were self-focused rather than family focused, wondering what they should do rather than what will happen in the family.

One male in this group states: "I think the daughter is caught in some kind of loyalty bind. . . . Perhaps she is acting out M's concern. . . ." This response is not as emphatic as the male experienced respondents; there are many conditional words such as "perhaps" or

"some kind of." Another example also showed this. The male respondent said, "I would probably begin with this family by thinking of them from a systems perspective. I would also wonder about the function of the older child." This respondent "wonders" about the older child while the more experienced male made an hypothesis about him.

Overall, the females in this experience level were not rated as very different from the males. They too were not poised for intervention as were the more experienced therapists, and they were seen as using conditional words. Said one woman, "There seems to be a lack of clarity of boundaries." The model from which these women were working was not clear to the raters or well-integrated. They gave assessments which covered several models. Here, for both males and females at the intermediate experience level, it appeared that they had not yet had enough experience to integrate theory and experience nor a chance to develop their own theory as a jumping off point for action. Said one respondent, "I'd be looking and assessing with strategic theories, I think, both MRI and Milan and perhaps Haley." She would be looking and assessing. The raters thought a sense of action was missing in comparison to the more experienced group.

Therapists with fewer than two years experience. The category of males with fewer than two years of experience had too few members to draw any clear conclu-

sions, especially because one was older than the other and had many more years of other kinds of therapy experience. The other male in this group gave a brief assessment but did not really back it up theoretically: "D has found a way to let her family know how upset she is with her father's illness. It is too hard to let anyone know in a more direct way."

The females in this category were rated as similar to the example just given. However, some did not risk an assessment at all, saying there was not enough information. In comparison, the respondents in the more experienced groups had had the same case presented to them and had found a wealth of information. The most experienced people had found enough information to make such thorough evaluations that their initial session could easily be surmised from the assessment. As with the males in this group, those women with more years of non-family therapy experience gave more complex answers.

Summary and discussion. In general, a comparison of the groups can highlight developmental stages of learning perceptual/conceptual skills. Those who had no general clinical experience hardly risked an assessment. Those with 2-3 years of family therapy experience made assessments but they were choppy and not well-integrated, seemingly waiting for refinement by the supervisor. After three years of experience the therapists in this sample

were viewed as making well-integrated assessments based on theory and experience, regardless of what the theory or experience was. Females in this most experienced category were dramatic, metaphoric, and focused on the IP and the function of the symptom in the system. Males, too, were focused on the IP but where the IP was in the hierarchy and on how well-defined the boundaries were. Experienced men's answers were emphatic, distant, whereas women's answers were more dramatic, from a closer stance, and also strong. This group was poised for action, the men more so than the women.

Although no statistical differences were found to refute null hypothesis 1, the coder analysis of tone, style, and quality showed differences in use of perceptual/conceptual skills among the three levels of experience. As mentioned above, within the most experienced level, a stylistic difference was detected between men and women, which reflected their way of thinking.

Reid (1983) and Tollers (1983) both have stressed that from their personal experience women need to more fully develop their conceptual skills. This study did not support their assertions. What it did confirm is that women and men think differently, which is consistent with cognitive style findings (e.g. Gilligan, 1982). In the most experienced category, women tended to present their assessments in a free-flowing style which included

emotion, drama, and metaphor. There was always a sense of competence and ability to act. Men presented their assessments in what might be considered a more theoretical manner only because they were less emotional, more emphatic, and used language more closely aligned to the theories. They were concerned with boundaries between people rather than the metaphor of a symptom. The men tended to discuss the aspects of the system as a whole rather than the real people who made up that system. They took different approachs to their concerns with relationship.

Men did offer a clearer sense of the one or two theories from which they were drawing while women appeared to be more eclectic. Place and level of training and experience probably affected this since more men had more education and traditional training than women.

Most of the differences found in perceptual/conceptual skills were found between experience levels. The least experienced obviously had the poorest skills. Neither the one least experienced male with no other experience nor the females with no other experience made much of an attempt to offer assessments. The lack of experience may have caused uncertainty. Stereotypically women are more afraid to take risks in showing their knowledge or abilities.

Abramovitz and Abramovitz (1976) addressed the issues of women who are moving from a student to a more

independent practitioner role. They discussed the difficulties these women had in taking a stand clinically and in trusting their own judgment. This research has shown that this dependence on the supervisor appears present for both men and women with fewer than 3 years of experience. It appears to be natural at the beginning of the progression in the development of independent family practitioners.

Hypothesis 2: Female and male therapists within three different levels of experience will show no differences in their ratings of themselves on a range of attention to task vs. attention to relationship.

To test this hypothesis respondents were asked in question 2 to rate on a 6-point scale how much attention to relationship or task they would use in this case. They were then asked to give a rationale and examples of what they would do with the family.

Rating scale. In order to determine if there were any differences between the respondents' self-ratings on the scale and the raters' ratings of the respondent, a Pearson's product-moment correlation coefficient was obtained. The coefficient was .8212, significant at the .001 level; therefore, there is a high correlation between the respondents' and the raters' ratings and therefore no significant difference.

The distribution of responses on the scale is shown in Table 7. Ratings tended to concentrate in the center of the scale. Therefore, the 6-point scale was condensed to a 2-point scale. Points 1-3 indicated a preference for relationship and points 4-6 indicated a preference for task. This condensation makes up Table 7.

As can be seen in Table 7, of the total sample almost twice as many respondents reported that they paid more attention to task than relationship. This was also reflected in the distribution of responses between males and females. Although the chi-square adjusted with Yates' correction for continuity shows no significance (x^2 = .048) in the difference in scores between males and females, as a whole some trends for future study can be seen. For example, the Fisher's exact test when used to compare the males and females within the three levels of experience shows significance within two of those levels. Differences were significant between males and females practicing 2 to 3 years (a = .06); there were also significant differences between males and females with fewer than two years of experience (a = .06). This suggests the possibility that greater experience decreases gender differences in relation to attention to task vs. relationship.

Given the small sample size, more testing must be done in this area to confirm findings. However, it can be

TABLE 7

SELF-RATINGS ON TASK-RELATIONSHIP SCALE

Career and Experience Level	Rating		
	Relationship (1-3 on scale)	Task (4-6 on scale)	Total
M, >3 yrs.	2	4	6
F, >3 yrs.	2	5	7
M, 2-3 yrs.	0	3	3
F, 2-3 yrs.	4	3	7
M, <2 yrs.	2	0	2
F, <2 yrs.	0	4	4
Total	10	19	29
Total M	4	7	11
Total F	6	12	18

said for this particular sample responding to a specific case:

1) For therapists with 2-3 years of family therapy experience, males rated themselves as giving attention to task significantly more often than did females;

2) For therapists with fewer than two years of family therapy experience, females rated themselves as paying attention to task significantly more often than did males; and

3) There is no significant difference in self-ratings between males and females in the most experienced group.

Other statistical findings. Several statistical tests were done. Frequencies for the coded open-ended responses were studied to determine where the highest frequencies were. Cross-tabulations by gender and experience level were then done. The variable of response to the task-relationship scale was also added to the cross-tabulation.

Given the very small number who were placed in each of the response categories statistically significant findings could not be drawn from this method of analysis.

Qualitative findings.

Therapists with more than 3 years experience. For both males and females in the most experienced categories, responses tended to cluster around the preference

for paying attention to task. Both, however, showed they were interested in both relationship and task, but they manifested this in very different ways.

Although only two women in the most experienced group claimed they were more interested in relationship than task, more than half of the women in this group chose some sort of joining as an important task. Joining involves the forming of a therapeutic relationship; the therapist uses it to let each family member feel the therapist is interested in him or her. One woman who rated herself more interested in relationship than task said she would "address each member of the family and spend time getting each member's view of the problem." One who rated herself more interested in task made a similar statement saying she would "spend time joining with each member" and would "sympathize with each's fears and difficulties." Another stated "Be sure to join all members initially." All three of these are similar verbal responses despite differing scaled responses.

The experienced males tended to rate themselves higher in attention to task but rather than choosing the task of joining, the majority actually said that both task and relationship were important, i.e., they stated it in their rationale rather than showing it by their behavior response. One who chose attention to relationship stated "I would employ both orientations," yet one who chose

attention to task also said "Both task and relationship are important." Another said he would start with relationship and switch to task in the second or third session.

In both experienced groups, men and women, answers were complete and specific. A clear sense of the therapist's thoughts and actions was present. Raters perceived that the males integrated their rationale and behaviors in a consistent manner. Women included themselves in their discussions, whereas men were more distant. Women said "I would" or implied it, "I would probably ask lots of questions." Men tended to list interventions. "Lots of circular questioning." "Clarify hierarchy." The most experienced males and females both gave answers which implied support to the family and answers which implied action in the session.

Therapists with 2-3 years experience. The middle group's responses were much less complex taken as a whole and separated by gender. The males, of which there were only three, all chose the same self-rating, "slightly more attention to task than relationship." Their rationales were brief and lacked complexity. Behaviors were very general, for example, "In the beginning I would look at behaviors and effects" with no explanation as to what he would do with it.

The females with 2-3 years of experience divided between attention to task and attention to relationship.

The behaviors they outlined were detailed but were focused on questioning or information gathering, and support as opposed to the action orientation of the more experienced group: "I will help the family list each individual problem"; "Begin by asking very detailed and specific questioning"; "I would, through questions, show the family their dilemma." These women seemed to have a gentle touch. They were very different from their male cohorts in that they gave detailed answers.

Therapists with fewer than 2 years experience. In the least experienced group the males rated themselves more relationship oriented than the females. All the males discussed feelings, "I would . . . bring out her feelings."

Some of the women in this group scored themselves as much more interested in task than relationship. The raters viewed many of the responses as sterile, as if they were taken from textbook readings. Rationales were more fully developed than were behaviors. Because of the complexity of therapist behavior in this model, this finding would be expected from this least experienced group. It was unclear what behaviors these therapists would try although they gave relatively complex rationales for their self-ratings. A representative example comes from a woman with less than one year of experience who rated herself a 4, "slightly more attention to task than relationship."

Her rationale read, "The development of a relationship is secondary in that it is a lever for change of a specific (behavior) problem." She said she would "assign tasks, not focus on relationship," which gave little clue as to what she would do.

Summary and discussion. Answers of the women in the least experienced groups were seen by coders as complex, detailed answers compared with their male counterparts. Of course the most experienced group was believed to have given the most complex, specific responses. Males in general were thought to have shown an interest in relationship, sometimes more so than the females, especially in the least experienced group. The caring and interest in the client family itself was most apparent to coders in the responses of the most experienced group.

The most experienced group once again showed no differences in their attention to task and relationship. Both sexes were equally concerned with each, but as with assessment skills, their expression of this was different. Experienced women said they were more interested in task but the task they chose consistently was joining, a relationship task; men in this group stated clearly a preference to include both the development of a relationship and the use of tasks in their work. Women seemed, in this instance, to be guided cognitively by the theory, i.e., structural/strategic theory calls for task oriented behav-

ior and one task stressed is joining (Haley, 1976; Minuchin, 1974). The males in this group seemed to rely on theory in a different way. They expressed an understanding of theory but did not include the task of joining as part of the theory having to do with the use of tasks. It is simply a difference in their styles of self-expression and integration of theory with personal style.

The middle group confirmed the conjectures of several theorists (Reid, 1983; Tollers, 1983; and Caust et al., 1981) who saw women as innately more interested in relationship-oriented rather than task-oriented behavior. In this group women chose attention to relationship significantly more often than men. They also described less directive interventions than the experienced women did, focusing on questioning and information gathering. This may be because of gender or experience level or a combination of the two. The findings suggest a confirmation of those theorists who think women have difficulty with action-oriented behaviors (Caust et al., 1981; Daniels, 1983), yet it is only some women who have this trouble, not all women.

The fact that the least experienced men were more interested in relationship than task in contrast to the women in this group is unexplainable with the literature and confusing given findings from the other two groups. A larger sample size may have shown clearer findings.

Hypothesis 3: Female and male therapists within three different levels of experience will show no significant differences in their ratings of use of indirect and direct interventions.

To test this hypothesis a 6-point scale was devised for the respondents to rate themselves along a continuum of how much they would use indirect or direct intervention with the presented case. As in the previous question, they were also asked to give written rationales and behaviors which were then coded by raters.

Rating scale. The Pearson's product-moment correlation coefficient for the comparisons of the respondents' choice in the scale and the raters' choice was .82, significant at the .001 level. Therefore, there was a high correlation or no significant difference between respondents' self-ratings and the opinion of the raters.

Table 8 shows the distribution of responses according to gender and experience level. This scale was condensed with values 1-3 representing use of indirect interventions and 4-6 representing direct interventions.

The chi-square for the comparison of males to females showed no significance, nor were there any significant differences within the three different experience levels or between the levels when males and females were combined. In other words, males and females regardless of

TABLE 8

INDIRECT-DIRECT INTERVENTIONS

Career and Experience Level	Rating		
	Indirect (1-3 on scale)	Direct (4-6 on scale)	Total
M, >3 yrs.	4	1	5*
F, >3 yrs.	4	3	7
M, 2-3 yrs.	1	2	3
F, 2-3 yrs.	6	1	7
M, <2 yrs.	1	1	2
F, <2 yrs.	4	0	4
Total	20	8	28
Total M	6	4	10
Total F	14	4	18

*No response from one male, >3 yrs. experience

experience did not rate themselves as different in terms of direct and indirect interventions. Therefore the null hypothesis is accepted.

Other statistical findings. There were no other significant statistical findings however the cross-tabulation highlighted some important points. Three women with more than three years of experience had rated themselves as using more direct interventions yet listed many indirect interventions. Four women with 2 to 3 years of experience who rated themselves as using more indirect than direct interventions gave examples of direct interventions. Women were the ones who seemed to cross over from what was said on the scale to what was listed as behaviors. However, as stated before, there was not enough of a difference between their self-perceptions and raters' perceptions to find this statistically significant.

In summary, there were no significant differences among the respondents on this section of the questionnaire.

Qualitative findings.

Therapists with more than 3 years experience. The most experienced therapists are more alike in this question than in the first two in terms of the quality of their answers. They gave thorough, well-integrated responses. They appeared ready to act (as in question 1). Rationale and behavior were consistent.

Both of these groups, male and female, gave responses which were more often coded as indirect interventions than direct interventions. The women tended to rate themselves on the scale as more direct than the men yet they gave what the raters considered as indirect interventions for examples. They gave rationales based on this specific family and on past experience. Rationales were varied. "This family plays hard ball," so he'd work directly; "To try to break through the massive denial," she'd work directly; "The family's blatant denial" would lead him to work indirectly.

Therapists with 2-3 years experience. Like the more experienced group, the middle group gave a variety of rationales for their choices, which were inconsistent with one another. One woman chose to use direct interventions saying "I do firmly believe in use of direct interventions. . . . It demonstrates respect for client integrity and self-determination." Another chose indirect interventions because she though that the challenge was for her to "respect their process" and find subtle ways to challenge the family to change.

Responses of the males in this middle group were seen as demonstrating a tendency toward use of direct interventions. There is a perceived desire to deal with indirect communication by using direct interventions.

Therapists with fewer than 2 years experience. As was the trend throughout, the least experienced group provided the least developed answers. Of the males the one with more experience gave the more complex answer. The other had difficulty formulating an intervention. "Hard to say at this point" is what he said. His rationale was based in some vague sense of theory: "If the problem is in directly expressing things so far, they may have trouble with direct interventions."

The women in this group all gave the same reason for choice of indirect intervention, i.e., to counter resistance. "Denial is so strong," said one woman. Three of the women sought more information before they would make much of an attempt at formulating an intervention.

Once again for this least experienced group there appeared to be a reliance on theory which was not well-developed and a notable lack of experience in formulating interventions. Some were more willing than others to attempt discussing interventions.

Summary and discussion. Overall this question yielded the most inconsistent responses. Rationales for completely different actions were often the same. Opinions of the family's process were expressed with such varying tone from "This family plays hard ball" to wondering "if the problem is in directly expressing things."

This question more than any of the others calls for very case specific answers. It is here that the interaction between the therapist and the family comes into play most. This is where the therapist has the least control and can do the least planning because the next step, though guided by theory, is also guided by the family's response to the intervention.

The literature in this area is also confusing. Caust et al. (1981) think women who are drawn to this field are interested in using direct interventions but others (Sheely & Anderson, 1982) say because of female sex-role stereotypes which characterize women as one-down or manipulative, they would be better at indirect interventions. There is the assumption that men would tend to use direct interventions more.

In discussing this and the other skill categories, the authors do not use the fact that therapists tend to be a more androgynous group than the general population (Bachtold & Werner, 1970, 1971). They therefore may be flexible and able to take on many seemingly contradictory behaviors.

As Sheely and Anderson (1982) stress, the therapist must be able to take the information within the therapeutic system and respond with whatever behavior is necessary. Therefore, a wide range of behaviors is necessary. Each therapist was responding to a specific moment in time

in the case vignette. Therefore it is difficult to know if each respondent would have this broader range of behaviors available to them.

Hypothesis 4: Female and male therapists within three different levels of experience will show no significant differences in their ratings of their directiveness.

Again, a 6-point scale was presented to the respondents for self-ratings on directiveness with this case. Rationale and behavior were requested and then coded by raters.

Rating scale. Once again the Pearson's product-moment correlation coefficient showed a high correlation between respondents' self-ratings and raters' ratings, .7491, which is significant at the .001 level. Therefore the two ratings were very similar.

On the rating scale responses clustered at "much more directive than non-directive" and only two respondents, one female with 2 to 3 years of experience and one female with fewer than 2 years of experience, rated themselves as non-directive. Three males and two females rated themselves as very directive. When the 6-point scale was condensed into a 2-point scale, which divided responses into directive and non-directive, 93% of all cases were in the directive category. Therefore, the null hypothesis is accepted for this sample using this case.

Other statistical findings. Once again, very few significant statistical ratings occurred. The most often rated category of rationale was one where the therapist discussed themselves, their experience or style preference. Nine females and five males gave this response, not a significant difference. Of the 10 who used theory for a rationale, four were the most experienced men, one was a woman in that category, two were males with 2 to 3 years of experience, two were females with 2 to 3 years of experience, and two others were females with the least experience. This shows only a non-significant trend toward males using theory more than females.

Fifteen respondents gave examples of what were coded as direct tasks and 14 gave examples of what were coded as indirect tasks. These respondents may have been overlapping, with subjects giving examples of each category of behaviors. Because respondents gave ratings of themselves as directive yet also may use either direct or indirect tasks, a trend toward respondents differentiating between directiveness and types of interventions was seen. In other words, a therapist can be directive and use a wide range of interventions, direct or indirect or a combination.

Responses to this question showed a trend toward males using what was coded as theory to explain their

choices and more experienced therapists using what was coded as preference or past experiences as rationales. The qualitative patterns highlight this and are outlined below.

Qualitative findings.

Therapists with more than 3 years experience. The experienced males and females rated themselves as very directive. The rationale the raters most often saw was their preference for this behavior. Interventions and rationales were seen by the coders as assertive, clear, directive and positive. Stated one woman, "It works for me. I want to convey to the family that I can and will handle them." Some behaviors she would use included, "Give some assignments and follow up on them, set the appointment time, insist on their attendance." Another female respondent said she chose a directive way of conducting herself because "It's my style most of the time -- also, I feel it helps a family to feel more secure if the therapist is clearly in control."

In the same vein, a male cohort stated, "I tend to be an active therapist, directing by my style of questioning and task giving." Said another, "By staying in control of the flow of information by my questioning style, I am the director." These were all directive responses and can be interpreted as self-assured responses.

Therapists with 2-3 years experience. The men with 2-3 years of experience chose a directive style because of what they described as requirements of the case rather than their personal styles, for example, "This family appears enmeshed and in need of action type therapy. . . . Directive approach would help to facilitate that action", or, "I feel this family needs to be restructured in its relationships and that they will be more open to directive interventions which they can clearly accept or refuse."

The women gave two sets of responses which were coded as either style preference or because of case experience: "It feels comfortable to me," "I am very directive with all of my clients," or "In my experience I have found out that most families feel pretty nervous and apprehensive . . . they expect the therapist to know what he/she is doing."

These women were sensitive to establishing guidelines for therapy but otherwise offered less directive tasks than the more experienced group, mostly questioning, although one stated more emphatically she would use "purposeful questioning." The males also consistently gave questioning as an intervention.

Therapists with fewer than 2 years experience. Style was the reason coded when the least experienced males described themselves as directive. They were very

different from one another in the content of their responses, probably because of differences in years of experience practicing therapy in general.

Two women were coded as using the rationale that there is a sense of urgency in the case and therefore a need for being directive. Others were seen as using style preference for a reason. There were a variety of responses here. They listed some specific interventions in many cases.

One least experienced woman said she would be non-directive because of her inexperience. She would use "listening, non-verbal responses, supportive comments, and joining." She appeared to be at the earliest point in her development of learning and assimilating family therapy. All others would be directive they said.

Summary and discussion. Almost all of the respondents said they would be directive, confirming Caust's et al. (1981) assertion about women family therapists' desires to act in this way in sessions. Two types of rationales were used to explain the directiveness of the therapist, style preference or some aspect of the family. The most experienced group referred to style; the middle group males used the case to explain their choice while females used preference or past clinical experience; the least experienced group most often referred to style

although two women chose directiveness because of a sense of urgency with the case.

The comparison of the most experienced two groups may show that the middle group has not yet incorporated directiveness into their style but still perceive it as theory related. It may be that once learned and practiced, directiveness becomes a part of style rather than something which is used because the theory requires it. This explanation, however, falls short when the least experienced group is considered. It is interesting that style was the category most often selected for this group. Perhaps these younger therapists are drawn to the theory in order to use some of their more directive qualities.

This quality of directiveness was addressed in the literature review. Yogev and Shadish (1982) had found that beginning women therapists practicing individual therapy were found to be less directive and active than male cohorts, even those women who rated themselves as androgynous. Therefore, self-perception of style may not reflect actual behavior. Observation of family therapists would add to the findings of this study.

Hypothesis 5: Female and male therapists within three different levels of experience will show no differences in their self-ratings of competence as family therapist.

Rating scale. This scale provided the therapist an opportunity to rate her or himself on how competent she or he felt as a family therapist. (See Table 9.) The majority (16) rated themselves as somewhat competent; 6 rated themselves as very competent; and 5 as "neither competent nor incompetent." It was the most experienced who rated themselves as very competent except for one female with 2-3 years of experience. Another respondent in the most experienced females group rated herself as somewhat incompetent. Within the 2-3 years of experience group both men rated themselves as somewhat competent, yet only three women did; three others rated themselves as neither competent nor incompetent. Chi-squared showed no significant correlations between ratings of competence and membership in an experience-gender cell. Because of this finding of no significant differences, the null hypothesis is accepted.

Discussion. The categories were divided purposely to eliminate the more general choices of "competent" or "incompetent." This was done to determine if any one sample group would rate themselves higher than another. Therapists at all levels of experience rated themselves as somewhat competent. It may be assumed that this rating is relative to their experience. These self-perceptions must be tested through observation to draw any further conclusions. It is interesting to note, however,

TABLE 9

COMPETENCY RATINGS

Career and Experience Level	Very Competent	Somewhat Competent	Neither Competent Nor Incompetent	Very In-Competent	Total
M, >3 yrs.	3	3	0	0	6
F, >3 yrs.	2	4	0	1	7
M, 2-3 yrs.	0	2	1	0	3
F, 2-3 yrs.	1	3	3	0	7
M, <2 yrs.	0	2	0	0	2
F, <2 yrs.	0	2	1	0	4
Total	6	16	5	1	29
Total M	3	7	1	0	11
Total F	3	9	4	1	18

that some women did rate themselves as very competent which is somewhat contrary to the McMaster findings (Woodward et al., 1981), where women underestimated their skills.

Additional research findings

There were five more questions on the questionnaire which pertained to skills and therapists' perceptions of themselves by others. Findings for each question will be discussed below.

Question 6. This question asked the therapist to list additional skills he or she would like to acquire. Responses were categorized in two ways--by categories which were coded and included in the statistical analysis, and by observation of trends by the raters.

Frequency distributions of coded responses showed that 14 (47.2%) respondents were interested in increasing perceptual/conceptual skills, 8 females and 6 males. There were no other high frequencies, yet the raters in their own computations and readings did find patterns of responses.

In order to ascertain if any other trends could be determined, each response for this question was written out on a chart. Similarly worded responses for each respondent were charted in the same row in order to

develop a visual means of determining trends. These findings are theme oriented and supplement other findings.

Therapists with more than 3 years experience. Therapists with more than three years of experience gave very specific answers. One area often chosen for improvement was perceptual/conceptual skills such as "moving from hypotheses to intervention more quickly," "conceptualization," and a "better ability to conceptualize in systems theory." Many of these offered a sense of movement from theory to action. Fifty percent of the men in this category and 42% of the women gave responses coded as this skill, which is interesting to note because they were rated as having the best perceptual/conceptual skills in general.

Indirect interventions, specifically circular questioning, were also chosen by 50% of these experienced males. Only one woman in this category chose circular questioning.

Fifty-seven percent of the experienced women chose some sort of skill involving the use of self as therapist. One woman gave this specific answer which addressed some of the issues raised in the literature concerning women's joining and overinvolvement (e.g., Reid, 1983):

> I would like to have a more accurate sense of distance between me and the family--the distance which is most therapeutically change-producing and healing for the family. I would like to recognize cues telling me that I am too close to see the

> whole picture that needs to be seen (usually where I am). I would also like to be more skilled at knowing when and to whom to move closer or away from in order to unbalance the system to facilitate change without risking losing the family in treatment.

Two experienced men chose this. The only other group which had respondents for this skill was women with 2-3 years of experience. Examples of this skill include, "a better sense of distance between me and the family; the distance most therapeutic and change producing," as stated by an experienced woman, simply, "use of self," as stated by an experienced male. Another male in that category said he wished "to continue evolving as a nonjudgmental therapist, whose own values are not a hindrance in my effective work." A woman with 2-3 years of experience wished to "use more of my creativity and spontaneity."

Therapists with 2-3 years experience. Respondents with 2-3 years experience chose the increase of knowledge of systems theory as a goal most often. Two men and two women also wanted more knowledge of non-systems theory. Women also made comments coded as an interest in increasing perceptual/conceptual skills (42% of the group).

Therapists with fewer than 2 years experience. Out of the two least experienced males, one chose "more experience" as did 75% of the females (3 out of 4). "More

experience in the room," said one female respondent; "more of everything," remarked the man.

Summary and discussion. One point of interest is that one very experienced woman and one with 2-3 years of experience wanted more experience in general whereas only one male did and that was an inexperienced male. The least experienced were seen as voicing a desire for acquiring general experience. The next group wanted more theory. The most experienced group wanted clearer ways to move from that theory to action using oneself.

This transition from the least experienced to the most experienced is reminiscent of Cleghorn and Levin's (1973) categorization of family therapy skills from basic to advanced to experienced. The therapist with the most experience could work at many levels at once translating perception to theory and theory to action. This sense of action has characterized the most experienced group throughout this data analysis.

Questions 7 and 8. These two questions will be considered together because they both are concerned with family perception of the therapists. Question 7 asks the therapists what they think families think of them, while question 8 asks how they would like to be viewed. Analysis of data was conducted in the same way as it was for question 6, with the development of coding categories and of qualitative patterns.

Frequencies showed that 24 (83%) respondents thought that families felt positively toward them; 16 women, including all with 2-3 years of experience, and 8 men, 50% of them inexperienced. Sixteen, 6 men, all but one of whom was most experienced, and 10 women, who were evenly distributed, related that the family viewed them as helpful. Thirteen said the family might call them pushy, hard, or directive, 5 men and 8 women, 6 of whom had 2-3 years of experience.

Twelve of the therapists were pleased with how they thought the families viewed them, 5 men and 7 women. A positive feeling was desired by 17 (59%), 10 women and 7 men. Fourteen wanted to be seen as helpful, including only 4 men who had fewer than 3 years of experience. The remaining 10 women were evenly distributed. This pattern does not account for the 16 respondents who said "helpful" in question 7 and then said "same as #7" in question 8.

Other patterns which the raters found were that few people used negative words to describe themselves, only 2 women who said "stupid" and 1 man who said "unsure of self." There was also a desire by 3 women and 4 men to have the family see themselves as responsible for change and hope that the family learned to solve their own problems. Both males and females, as stated above, wanted to be viewed positively by the family. One man even said, "I must admit it would be nice to have more families say

'Thanks for helping us change,'" despite that the models say that is not what a therapist should expect.

For the most part therapists would like to be and think they are viewed as helpful and as possessing positive personal qualities.

Questions 9 and 10. These questions asked the respondents to report how they think their supervisors view them and how they would like to be viewed. For question 9, the category of positive personality traits like warm, caring, or concerned were rated 11 times, 8 times by women evenly distributed in the two most experienced levels. Ten people, 7 of them women, were rated as wanting to be viewed as eager to learn and take risks. Sixteen respondents, including 1 of the most experienced women, were categorized as saying they had areas for improvement like the need for more experience or more theory. That woman's statement was rather eloquent: "I need to be more informed as a bystander so I can use myself more as an instrument of change," she said.

In describing the way they wished to be viewed, 44.8% said "same as #9", indicating satisfaction with how they think they are viewed already. There were no other patterns in the responses.

Some differences noted by the raters include that once again the most experienced group was the most specific. Men seemed just as interested as women in engaging

people and putting them at ease. A similarity was that everyone seemed to care how they were viewed by the supervisor and wanted to be viewed positively except for one very experienced male who said he had difficulty being supervised and wished he argued his point more.

Other findings

The other findings merely strengthened some of the prior conclusions which showed a clear thread of developmental stages of the family therapist. Least experienced therapists wanted and needed more experience of all kinds; the middle group wanted and needed more theory and more specific experiences; the most experienced gave the best integrated answers and the most specific ones. They showed a sense of specific skill areas which they felt needed improvement. From the least experienced to the most experienced, there is movement from theory to action. There is a concern with first theory in the less experienced groups and then action in the most experienced groups. There is an awareness of the place of the use of the self by the most experienced group. This movement toward action was outlined somewhat differently by Tomm and Wright (1979) who said the four functions of the family therapist are 1) joining, 2) problem identification, 3) change facilitation, and 4) termination (p. 228). The responses gathered during this study suggested that

the least two experienced groups were not yet comfortable with the steps necessary for change facilitation. The most experienced group seemed to have the skills and desire to perform them even better.

Integration of results

In this chapter the results of the statistical and qualitative analyses were presented. Certain patterns were highlighted concerning each hypothesis. In this section, a brief integration of the results is presented. One significant statistical finding was the high positive correlation between the respondents' self-ratings and the coders' ratings of the respondent on the same scale.

Only one hypothesis developed for the study could be accepted using statistical data and that could be accepted only for two levels of experience. More specifically, significant differences were found on respondent self-ratings of attention to task and attention to relationship between males and females with 2 to 3 years of experience, where males rated themselves as giving attention to task significantly more often than did females, and between males and females with fewer than 2 years of experience, where females rated themselves as paying attention to task significantly more often than did males.

The most striking differences in the study were found within the qualitative analysis. In every category

of responses the complexity and integration of answers decreased with the decreasing levels of experience. The most experienced were seen by raters as giving a sense of action and building on past experience through their answers. The thought processes of these more experienced family therapists were perceived as clear and well-developed. These therapists seemed to address the case from the individual standpoint of the case itself and with a fully developed use of theory and experience. Their ideas for therapist action were more specific and backed with what was seen by the coders as theoretically sound justification. The other less experienced groups talked about theory but did not mention experience or give specific ideas for therapist action. The middle group was heavily reliant on theory, but seemed to be waiting for more input from the family or a supervisor before moving to action. The least experienced group made attempts at using theory to discuss the case but their lack of experience was a notable hindrance in the complex use of theory or any attempt at the development of interventions.

Within the most experienced group, the major differences were found within perceptual/conceptual skills across all questions. The differences in the ways males and females think became apparent. Males were rated as analytical and distant. They looked at the case as a whole and used structural terminology. Females were meta-

phoric and often used the term "loyalty." They focused on the IP's symptoms, and were dramatic. They were interested in the emotional aspects of the case. Both genders were viewed by the raters as action-oriented, self-assured, and independent thinkers.

The middle group was seen as more theory oriented than strategy oriented. Males and females gave general responses, although the women answered in more detail. The behavior of the females was focused on questioning and information gathering, while men were most concerned with following theory. The women would also rely on personal style or preference.

It was most difficult to draw conclusions in the least experienced group because of the low number of respondents and the vast differences among the men. Answers were often choppy and theory and intervention were judged not to be well integrated. They often said they were in need of more information.

The major differences in regard to the hypotheses were observed primarily in the qualitative patterns as discussed above. Experience level rather than gender was the major differentiating variable in quality and type of therapeutic and professional self-analysis. Overall this finding is contrary to the literature which suggested major gender differences (Caust et al., 1981; Sheely & Anderson, 1982; Reid, 1983; Tollers, 1983). Therapists

seemed to move from a timidity about using theory and formulating behavior to a dependence on theory to use of theory as a stepping stone for action. Specificity of action to be taken was what separated the most experienced group from the rest. Those small gender differences which were noted were inconsistent. The pattern regarding the therapeutic analysis and action was found to be experience-based.

Two major gender differences appeared in the study: 1) In the middle group males were more reliant on theory than were females, and females acted according to a personal style; and 2) The most experienced group showed a stylistic difference in the way they used theory to organize the case material. The developmental stages of learning to do this work must be stressed in order not to fully blame differences on gender.

C H A P T E R V

CONCLUSIONS AND IMPLICATIONS

Organization of the Chapter

Several goals guided the design of this research. One goal was to determine differences among female and male structural, strategic, and systemic family therapists within the six skill categories developed in the methods section. Another goal was to determine the interaction of experience and gender with other therapist variables. A byproduct of the research was the testing of a family therapy research instrument and method, especially given the infancy of this kind of research.

Once results were determined, another goal was to use the literature review in combination with the results to discuss any implications this research may have had for training of family therapists. If special requirements for the training of female therapists were indicated, that would be highlighted. These goals as well as the implication of the study are discussed in this final chapter.

Summary of Major Findings

Results of this research were based on a sample of 29 structural/strategic and systemic family therapists who worked in community-based settings. There were 18 female

and 11 male respondents who fell within one of the following experience levels: 1) those with more than three years of family therapy experience; 2) those with 2-3 years of family therapy experience; and 3) those with fewer than 2 years of experience.

The demographic characteristics of the sample were determined in several areas. The mean age was 35.8 with the distribution of age being similar for both genders. More males than females held the doctorate degree and more females than males received their training on the job. Men tended to be trained in formal training programs. This last statistic is important when considering results because the theory base of men was judged as more clear and less eclectic than that of women.

On the issue of theory base, in general women chose the structural/strategic model more often than men. This was statistically significant for the over 3 years experience level.

It was not surprising to find that, in general, men had more education and higher degrees than women. This was consistent with other research (Gurman & Kniskern, 1978; Russo & Vandenbos, 1981). It also may be an explanation for later findings as is discussed later.

In general, major differences were found among experience levels rather than between sexes. Few significant statistical findings occurred; differences were quali-

tative rather than quantitative. Overall a sense of the progression of learning family therapy became evident. The least experienced group did vague assessments and gave little information on behaviors they would use. The middle group used theory well and used such behaviors as questioning or information gathering. Sometimes they gave only a vague sense of action. The most experienced group integrated theory and action. They were specific both in what they would do and what skills they had or would like to have.

More specifically, therapists with the most experience were rated as giving the most integrated, complex responses. They also were judged as being action-oriented, i.e., so clear with their assessments and rationales that what they would do next with the family was evident.

There were qualitative gender differences found in this most experienced group. Women were judged as using a free-flowing narrative style which included emotion, drama, and metaphor. They were focused on the IP and the function of her symptoms. These women were interested in both the use of tasks and the use of relationships with the family, especially in the area of joining. They rated themselves as directive most often giving the rationale of personal style for this choice.

The males in this most experienced group were judged as using emphatic, more distant assessment styles. They seemed to have a list of ideas from which they drew. They were rated as drawing most often from the structural model in terms of assessment even though, in general, they rated themselves as systemic. These men were equally interested in using tasks and their relationship with the family to effect change. Like their women cohorts, they rated themselves as directive because of personal style preference.

The group with 2-3 years of experience were judged as being characterized by use of conditional words and theoretical answers not backed by action-oriented behavior. They were seen by the raters as making decisions based on theory or the specific case rather than as having a cognitive map based on practical experience from which they could draw. The kinds of interventions they gave for examples were viewed by the judges as not action oriented but rather concerned with more questioning and further assessment.

The women in this mid-level experienced group were more interested in relationship than task, as predicted by several theorists (Caust et al., 1981; Reid, 1983; Tollers, 1983).

It was difficult to make generalizations regarding the least experienced group because the sample size was so

small (n=6). It was clear to the judges, however, that assessments were not well developed and discussion of behaviors this group would make were even less developed. Indeed, some members of this group would not even risk making an assessment saying there was not enough information.

Overall differences found by the raters were among experience levels rather than between genders. There was a progression of learning and accumulation of skill from the least to the most experienced group.

Implications for Training

The research results have several implications for training. When the findings are taken as a whole they demonstrate the steps which may occur in the learning of family therapy. Therefore, one implication for training is that the student can be told what to expect in terms of her/his progress in skill acquisition and the development of cognitive maps or experience from which to draw. This can be reassuring to the student who may become frustrated by watching the masters work, perhaps feeling they should be able to reproduce the experts' methods right away.

The findings on skill acquisition have another implication for training. Perhaps a way can be found for trainers to speed up the learning process. The student could be exposed to more families and be required to do

many assessments, using written vignettes as well as live families. They should work alone and in teams. Less experienced students could work with more experienced students in order for the novices to draw from the more experienced. More opportunity actually doing the therapy would speed up learning dramatically. Of course many trainers may do this already. Since this research did not cover that area, only suggestions are offered here.

A final implication for training has to do with style. The research showed some differences in style between men and women but not whether the differences were detrimental. If the student is given the opportunity to learn her/his style and integrate that with theory, she/he can work with classmates and trainers to refine those characteristics which are helpful and to develop new ones through practice. The research showed that to expect specific sex-typed behaviors from a trainee would be unfair. Also to judge any sex-type behaviors as negative would be detrimental. As Tollers (1983) showed in her reframing of women's stereotypic behaviors, some behaviors viewed as negative in general may be positive in regard to therapy. Allowing students to become familiar with their styles in a non-judgemental way and then having them try new behaviors rather than seeing their behaviors as wrong or bad (McDaniel, 1983) can be beneficial and a positive learning experience for the student.

In conclusion, assumptions regarding the difficulties women may have in doing family therapy were not confirmed in this self-report study. However, findings from the research led to three implications for training in the areas of assessment, acquisition of experience and theory, and style.

Research Concerns

The purpose of this study was to test some implications regarding gender differences in therapy practice which were made in the literature but which were not based on empirical studies. The written questionnaire was used to obtain a large enough sample from which to test hypotheses and identify patterns. However, this research is considered a case study because it is testing new waters, the sample size was small, and the instrument was previously untested.

Several difficulties were found with the research, including the method and the instrument. The sample was drawn from community-based practitioners. This was positive in that it gave a heterogeneous base from which to draw. However, given productivity demands, this group has very little unstructured or discretionary time. The questionnaire was long and demanding. These variables combined to produced a low response rate.

Since the questionnaire was previously untested, there may have been problems which were not apparent. The case vignette may have contained some gender bias, or the case may not have been representative of a case typically seen at a community-based mental health clinic.

The questionnaire allowed for open-ended responses which gave the therapists the opportunity to answer freely using self-report. Therefore, responses may not accurately reflect behavior. Only with observation can self-report be confirmed for accuracy.

There were many complex responses to the questions which gave the results richness but made coding difficult. Indeed, few statistically significant results were found. The most useful findings were qualitative focusing on style, tone, and quality of responses. Although this research produced good inter-rater reliability, developing the coding system was difficult. Categories may have been too broad, too narrow or poorly defined. Rank of category may have influenced the raters.

Other family therapy researchers have had difficulties making sense of responses. Tucker and Pinsof (1984) were unsure if their lack of findings was due to their instrument, their method of analysis, or that indeed there were no significant differences in their sample. They gave little discussion of what their coding was like so it is difficult to draw further resemblances. Others

have had difficulty with interrater reliability (Pinsof, 1979). New research and analysis methods are constantly being tried (Schumm, Bugaighis, & Jurich, 1985). Family therapy research is a relatively new and growing field which needs more and more research to confirm or build theory. This study has highlighted areas on which others can build. Some possibilities are outlined below.

Future Research

Several areas for further research have grown out of this study:

1) The instrument can be improved in two ways. It can be tested with larger and different samples. Also the coding system can be reworked or refined to highlight different areas of responses.

2) Therapists can be observed and rated on the actual performance of the skills categories developed here. This would involve the development of an observation method, clear rating categories, and the thorough training of raters. It would require good interrater reliability, something which has been lacking in the field this far. If this type of study could be done, it would add to the research the dimension of actual rather than stated therapist action.

3) A study to test for trainer sex-role expectations could be devised much like some studies highlighted

in the literature review (Billingsly, 1977; Kitchener et al., 1975). This would involve use of an instrument which could tease out trainer bias, for example, use of a case example which deleted therapist sex followed by a rating by the subject on the therapist's performance. Another method for studying trainers might be through observation. It would be interesting to see if those who discussed their work with trainees (Reid, 1983; McDaniel, 1983; Tollers, 1983) really worked the way they said they do.

4) A training series which addressed skill acquisition, the use of personal style and the integration of the two could be developed and tested for effectiveness in speed of learning new skills. This could be much like that described earlier.

5) This research could be replicated with larger samples. As part of this, variables such as experience level, graduate degree, gender, or place of training could be held constant. A study which tested for skills and qualitative patterns could be carried out over time. The same group could be tested at the beginning of training and over a specified period. One important replication would be with trainees because the literature seems to focus on this group. Very different results might be obtained if a larger group of inexperienced therapists were studied using both self-report and observation.

6) Other studies could concentrate on more specific areas for example: research on the setting where therapy is practiced and whether that affects therapist behavior or attitude; a study of the personality characteristics of family therapists as opposed to individual therapists or the general population; an in-depth study on the attitudes of women family therapists toward their work, training, and male colleagues.

Certainly there are many research topics which pertain to women and family therapy. Since there have been so few, they would be a welcome addition to a growing body of literature.

Summary and Conclusions

Research was developed and carried out to test assertions in the literature concerning women family systems therapists. A written questionnaire was developed and used on a sample which had never before been surveyed. Trends were found which showed few gender but many experience level differences. It appeared from the study that many of the personal assertions in the literature regarding sex differences in therapist conceptions and actions need to be re-examined and perhaps dropped. These authors ascribed problems or weaknesses to women therapists which did not hold under close examination or which may dis-

appear with experience. Implications and suggestions for further research were made.

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APPENDIX A

LETTERS TO AGENCIES

LETTER TO EXECUTIVE DIRECTORS REQUESTING
THEIR PARTICIPATION

751 Bay Road
Amherst, MA 01002
September 10, 1984

(NAME AND ADDRESS OF EXECUTIVE)

Dear :

I am in the process of gathering data for research being conducted in conjunction with the Human Services and Family Therapy speciality areas at the University of Massachusetts, Amherst, School of Education.

The primary interest of the research revolves around the practice of family therapy in community-based mental health clinics in New England. Several such clinics, including yours, were chosen because: a) (NAME OF AGENCY) is a public sector agency; b) it is a community-based clinic; and c) it is acknowledged as a clinic which provides high-quality family therapy.

I would like to survey any therapists at your agency who do family therapy, are family therapy supervisors, or who are intern or practicum students. Each survey should take no more than 45 minutes to complete. The results of the research will be available to you, your agency, and the individual participants. I will be available for discussion of these findings at the termination of the project.

I will be contacting you within the next two weeks to set up a time to discuss this research project more fully with you and/or your staff.

Sincerely,

Serena Lurie Bloomfield

THANK YOU LETTERS TO THE EXECUTIVE DIRECTORS
OF PARTICIPATING AGENCIES

751 Bay Road
Amherst, MA 01002

(NAME AND ADDRESS OF DIRECTOR)

Dear :

Thank you very much for your participation in the research on the practice of family therapy in a community-based public sector clinic. Your assistance and that of your staff has been very helpful and is greatly appreciated.

If you requested a summary of results, that will be forwarded to you by the spring. If you or anyone on your staff did not request a summary and would like one, please feel free to contact me at 737-2679 (days) or 253-2725 (evenings).

Thank you again for your participation.

Sincerely,

Serena Lurie Bloomfield

APPENDIX B

QUESTIONNAIRE

The Practice of Family Therapy in Community-Based Mental Health Clinics

Serena Lurie Bloomfield

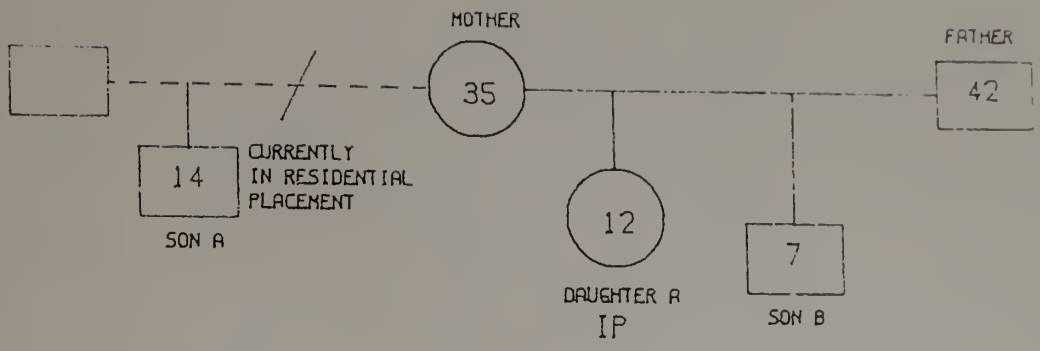
1984

PART I

INSTRUCTIONS: Part I consists of a family therapy case vignette followed by four questions. When reading the case, please assume the following concerning the context:

1) You are the family therapist;
2) You are seeing the family without a team;
3) The family is typical of those seen at a community based-mental health clinic;
4) You are seeing the family at such a clinic.

The vignette consists of a simple genogram of the immediate family, a description of the family, a description of the presenting problem, and dialogue from a recent session. You will then be asked some questions concerning the case. Please feel free to use as much detail as necessary in your answers. You may use the margins or attach additional pages if you wish.



THE GREEN FAMILY

DESCRIPTION OF FAMILY: This family, the Green family, consists of Mother, 35, Father, 42, Daughter, 12, and Son B, 7. There is also a 14-year-old son who was born out of wedlock from a different father prior to the marriage of mother and father. This son was put into foster care at an early age but may be returned very soon, according to a social worker who contacted the mother.

DESCRIPTION OF PRESENTING PROBLEM: The family was referred for therapy by their pediatrician because the daughter had recurring headaches for which a specialist found no physical basis. The father was overweight, had heart disease, and smoked heavily. The mother was overweight, had recurrent migraines, and smoked heavily. The younger son had no symptoms. The mother was an only child, and father's family lived in a faraway state.

Father's doctor referred to father as "a walking time bomb," meaning he could die any minute. Daughter's headaches seemed to coincide with father's illness. Her headaches usually developed when he felt sick, out of breath, or weak. Her parents would then have her lie down in her room and would check her every 10-15 minutes.

Both parents agreed daughter was "The apple of father's eye," and was afraid father would die. Mother and father showed little emotion when discussing the possibility of father's death.

SELECTED DIALOGUE FROM A RECENT SESSION:

F: I have had a heart attack once a year for the past three years.

M: The doctor says he's a walking time bomb.

F: (lighting a cigarette) You know when summer comes I won't even be able to make it up these stairs [to the therapist's office].

Ther: Do you think you will die within the next six months?

F: No (wheezing), I'm sure of that.

M: He could have another heart attack soon (lights a cigarette). It's that time of year. She [daughter] gets afraid of that. She blames me, you know, because I'm the one that takes him to the hospital and she thinks it's my fault.

F: Yeah, she gets upset.

Ther: (to daughter) You're afraid father will die?

D: (Nods, looks at mother)

F: It's gonna happen someday. She'll have (fumbles for aspirator) to learn to deal with it some time.

D: (Watches father pull out aspirator. As he puts it to his mouth daughter draws in a breath and holds it.)

INSTRUCTIONS: Now please refer to this vignette in answering the following questions. Please feel free to comment at length.

1. Tomm & Wright (1981) discuss the use of theoretical material in describing family interaction. The theoretical material may include actual formal theory, specific concepts, or the application of "previous learning to the specific therapeutic situation."

   Please make an assessment of the family in this vignette using theoretical material.

2. Although the concepts are not mutually exclusive, some therapists choose to pay attention to their relationship with the family and some choose to focus on using task-related methods in working with the family. Attention to relationship is when a therapist shows interest in developing a non-neutral therapeutic alliance with the family or in the therapist him or herself having a more personal connection with the family in order to affect change. Attention to the task-related aspects of the therapy occurs when the therapist focuses on performing tasks such as questioning, giving directions or other more problem-focused activities as the instruments for change.

2a. Below please circle the one statement which best describes how you would use yourself with this family in the areas of attention to task or attention to relationship. Please circle only one.

1. ALL ATTENTION TO RELATIONSHIP
2. MUCH MORE ATTENTION TO RELATIONSHIP THAN TASK
3. SLIGHTLY MORE ATTENTION TO RELATIONSHIP THAN TASK
4. SLIGHTLY MORE ATTENTION TO TASK THAN RELATIONSHIP
5. MUCH MORE ATTENTION TO TASK THAN RELATIONSHIP
6. ALL ATTENTION TO TASK

2b. What rationale would you give for your choice in 2a?

2c. What behaviors would you use with the family to demonstrate this choice?

3. Regardless of whether a therapist focused on task or relationship (above), she or he would choose to intervene in a family either using direct interventions or indirect interventions. Direct interventions address a problem head-on; they are suggestions which the therapist expects the family to follow. Also the benefit of direct interventions should be apparent to the family. Indirect interventions do not address a problem head-on but use less direct means. The benefit of these interventions may be less obvious to the family and the outcome may not be immediately apparent.

3a. Below please circle the one statement which best describes where you would focus with this family in terms of interventions. Please circle only one.

1. ALL INDIRECT INTERVENTIONS
2. MANY MORE INDIRECT THAN DIRECT
3. SLIGHTLY MORE INDIRECT THAN DIRECT
4. SLIGHTLY MORE DIRECT THAN INDIRECT
5. MANY MORE DIRECT THAN INDIRECT
6. ALL DIRECT INTERVENTIONS

3b. What would be your rationale for choosing those interventions?

3c. Please speculate as to what those interventions might be.

4. Regardless of whether a therapist uses direct or indirect interventions, he or she is more or less directive in his or her style. Directive therapists attempt to actively organize what happens in the session. Non-directive therapists take a more passive, non-leading role than the directive therapists.

4a. Given the above family, please circle the one statement which best describes how directive or non-directive you would be. Please circle only one.

1. VERY DIRECTIVE
2. MUCH MORE DIRECTIVE THAN NON-DIRECTIVE
3. SLIGHTLY MORE DIRECTIVE THAN NON-DIRECTIVE
4. SLIGHTLY MORE NON-DIRECTIVE THAN DIRECTIVE
5. MUCH MORE NON-DIRECTIVE THAN DIRECTIVE
6. VERY NON-DIRECTIVE

4b. In this case, what would be your rationale for your response to 4a?

4c. Please speculate as to what behaviors you would use to demonstrate your choice in 4a.

Please feel free to add any other comments about this case.

Thank you for completing Part I. The next two parts are shorter. Before going on, please feel free to comment on Part I if you wish.

PART II

INSTRUCTIONS: The next question asks you to choose one answer from the given choices. Please circle only one response for this question.

5. Please rate how competent you feel as a family therapist. (Circle one):

    1. VERY COMPETENT
    2. SOMEWHAT COMPETENT
    3. NEITHER INCOMPETENT NOR COMPETENT
    4. SOMEWHAT INCOMPETENT
    5. VERY INCOMPETENT

INSTRUCTIONS: Following are several open-ended questions. Please feel free to respond to them at length.

6. Many family therapists think they would like to have more skills than they do. What are the additional skills, if any, you would like to acquire?

7. Imagine for a moment how the families you have seen might describe you. What might they say?

8. Please describe how you would like to be viewed by the family.

9 Now, imagine for a moment how the supervisors you've had might describe you. What might they say?

10. Please describe how you would like to be viewed by your supervisors.

Thank you for your responses to Part II. Before going on to the brief demographic section, is there anything else you would like to say? Please feel free to comment here.

PART III

INSTRUCTIONS: Please respond to the following questions as indicated at the end of each statement.

11. Which of the following theories do you use as your primary theory base when doing family therapy. (Circle one):
    1. HISTORICAL (DICKS, STIERLIN, NATHAN ACKERMAN)
    2. INTERGENERATIONAL (BOWEN, NAGY, SPARKS)
    3. STRUCTURAL/STRATEGIC (MRI, HALEY, MADANES, MINUCHIN)
    4. SYSTEMIC (MILAN GROUP)

12. Your sex (Circle one):
    1. MALE
    2. FEMALE

13. Your age _____

14. Highest degree attained (Circle one):
    1. M.D.
    2. DOCTORATE
    3. C.A.G.S.
    4. MASTER'S
    5. BACHELOR'S
    6. ASSOCIATE'S
    7. OTHER _____

15. Year of degree: _____

16. Where did you receive your family therapy training? (Circle one):
    1. UNIVERSITY OR COLLEGE GRADUATE PROGRAM
    2. FAMILY THERAPY TRAINING INSTITUTE
    3. ON-THE-JOB TRAINING
    4. WORKSHOPS
    5. SELF-TAUGHT
    6. OTHER _____

17. How long have you been a practicing therapist?
(Circle one):

1. 0 TO UNDER 1 YEAR
2. 1 TO 2 YEARS
3. 2 TO 3 YEARS
4. 3 TO 4 YEARS
5. 4 TO 6 YEARS
6. 6 TO 10 YEARS
7. 10 TO 15 YEARS
8. 15 TO 25 YEARS
9. MORE THAN 25 YEARS

18. How long have you been practicing family therapy?
(Circle one):

1. 0 TO UNDER 1 YEAR
2. 1 TO 2 YEARS
3. 2 TO 3 YEARS
4. 3 TO 4 YEARS
5. 4 TO 6 YEARS
6. 6 TO 10 YEARS
7. 10 TO 15 YEARS
8. 15 TO 25 YEARS
9. MORE THAN 25 YEARS

Thank you very much for participating in this study. Your assistance has been greatly appreciated. If you wish to say anything else please feel free to do so here.

Please return the cover letter and complete questionnaire to the envelope and return it to the previously assigned person in your agency. Thank you.

APPENDIX C

LETTER TO SUBJECTS

751 Bay Road
Amherst, MA 01002
September 19, 1984

Dear Therapist:

The practice of family therapy is occuring in a wider range of settings than ever before. Presently little is known about the work of those therapists practicing either alone or with a team in community-based mental health clinics. Therefore family therapy curriculum may not be meeting the needs of those therapists.

You have been chosen to give your responses and opinions in this area of family therapy because you work for a community-based mental health center which is a public sector clinic and which is acknowledged as providing high-quality family therapy. In order that the results of this survey may best represent the thinking of this group of family therapists, it is important that each questionnaire be completed and returned. It is also important that you not collaborate with others on your responses.

You may be assured of complete confidentiality. Do NOT write your name on the questionnaire itself. However, please sign this letter below giving your permission for me to use your responses to your questionnaire and return it to the envelope. The paper will be separated from the questionnaire before it is read.

The results of this questionnaire will be made available to trainers and practitioners of family therapy. You may receive a summary of results by writing "copy of results requested" on the back of the envelope and printing your name and address below it. Please do NOT write this information on the questionnaire itself.

If you have any questions or comments please feel free to write or call me at (413) 737-2679 (days) or 253-2725 (evenings).

Thank you very much for your assistance.

Sincerely,

Serena Lurie Bloomfield
for the
Human Services and Family Therapy
Specialty Areas
School of Education
University of Massachusetts

I grant my permission for Serena Lurie Bloomfield to use my responses to this questionnaire for the purposes of her research. I understand my name or other identifying material will not be used in evaluating or reporting findings.

_____ _____

Date Signature

APPENDIX D

RATERS' SCORING SHEET

SCORING SHEET

Respondent #_____ Rater #_____

1. EXPERIENCE-FORMAL THEORY SCALE

1 2 3 4 5
Previous Learning Formal Theory

1b. Assessment Categories

_____1. Discusses the function of IP's symptom in the system

_____2. Comments on family members' internal states

_____3. Discusses case in terms of relationships among family members (dyads, triads) or sequence of interaction

_____4. Mentions hierarchy/subsystems

_____5. Mentions system stressors

_____6. Discusses or describes an intervention

_____7. Discusses family rules

_____8. Makes other hypotheses about family (not covered above)

_____9. Reiterates something discussed in text

_____10. Other _____

2a. TASK-RELATIONSHIP SCALE

2a1. Circle respondent's choice 1 2 3 4 5 6

2a2. Circle rater's choice 1 2 3 4 5 6

Respondent #_____ Rater #_____

2b. Rationale Categories

_____1. Discusses definitions as given in question

_____2. Discusses some aspect of family as a rationale

_____3. Discusses theory as a rationale for choice

_____4. Discusses how therapist would use self in forming relationship with family

_____5. Outlines task or intervention strategy--what task or intervention therapist would formulate

_____6. Makes hypothesis concerning the family

_____7. Therapist uses own past work experience as rationale

_____8. Therapist uses personal preference as rationale

_____9. NA

_____10. Other _____

Respondent #_____ Rater #_____

2c. Behavior Categories

_____1. Joining

_____2. Assigning in-session and homework tasks

_____3. Asking direct questions

_____4. Circular questioning (specifically)

_____5. Making statements

_____6. Positive connotation, positive reframing

_____7. Assessment, observation

_____8. Therapist-family boundary marking

_____9. Use of humor

_____10. Discussion of family's feelings

_____11. Use of self as model

_____12. Other _____

Respondent #_____ Rater #_____

3. DIRECT-INDIRECT SCALE

3a1. Circle respondent's choice 1 2 3 4 5 6

3a2. Circle rater's choice 1 2 3 4 5 6

3b. Rationale categories

_____1. Discusses some aspect of the family for rationale (not hypothesis)

_____2. Discusses theory as a rationale

_____3. Makes hypothesis re: family

_____4. Intervention strategy outlined

_____5. Therapist uses own past work experiences as rationale

_____6. Therapist discusses self, expertise, or style preference

_____7. Other _____

3c. Behavior categories

_____1. Joining

_____2. Interventions, strategies, or tasks which are direct

_____3. Comments uses to counter resistance (Indirect)

_____4. Tasks used to counter resistance (Indirect)

_____5. Therapist-family boundary marking; managing the therapeutic frame

_____6. Circular questioning

_____7. Discusses theory

_____8. NA

_____9. Other _____

Respondent #_____ Rater #_____

4a. DIRECTIVE-NON-DIRECTIVE SCALE

4a1. Circle respondent's choice 1 2 3 4 5 6

4a2. Circle rater's choice 1 2 3 4 5 6

4b. Rationale categories

_____1. Discusses definition

_____2. Discusses some aspect of the family

_____3. Discusses theory

_____4. Outlines intervention strategy

_____5. Therapist discusses self, expertise, or style preference

_____6. Uses history of treatment of this family

_____7. Discusses past work experience

_____8. Other _____

Respondent #_____ Rater #_____

4c. Behavior categories

_____1. Tasks, intervention strategies, Direct

_____2. Tasks, intervention strategies, Indirect

_____3. Therapist-family boundary marking

_____4. Circular questioning

_____5. Use of self as a way to influence

_____6. Questioning regarding the history of the problem ("Problem-Solving" Techniques)

_____7. Feedback to family

_____8. Boundary marking within the family

_____9. Joining

_____10. Comment to researcher

_____11. Direct questioning (not on history)

_____12. Other _____

Respondent #_____ Rater #_____

5. COMPETENCY SCALE

Circle respondent's choice 1 2 3 4 5 6

6. Additional Skills Categories

_____1. Relationship skills/use of self

_____2. Indirect techniques, tasks

_____3. Direct tasks, techniques

_____4. Perceiving, Conceptualizing, Theorizing

_____5. Do better at what I already do

_____6. Assessment skill

_____7. Interventions (in general)

_____8. Feel better about myself

_____9. More experience doing the work

_____10. New theories (e.g., NLP, psychodynamic, hypnosis)

_____11. Therapist-family boundary marking

_____12. More work with specific type of client (Hispanic, resistant, young children)

_____13. Other _____

Respondent #_____ Rater #_____

7. Family Opinion of Therapist

_____1. Family felt positively toward therapist (warm, caring, understood)

_____2. Therapist helpful (facilitative, helped, solved our problems)

_____3. Therapist seen as weird, confused, or strange

_____4. Therapist seen as directive, pushy, firm, hard

_____5. Other _____

8. Therapist's Wish of Family Opinion

_____1. Same as #7

_____2. Wants family to view therapist in positive way (warm, caring, good listener)

_____3. Helpful, facilitative

_____4. Weird, confused, or strange

_____5. Directive, pushy, hard

_____6. Other _____

Respondent #_____ Rater #_____

9. Supervisor Opinion of Therapist

_____1. Good joining skills

_____2. Experienced

_____3. Needs more experience

_____4. Good theoretical skills/well-read

_____5. Needs more theory, reading

_____6. Lists positive traits (warm, caring)

_____7. Will do anything for client, works hard for client

_____8. Lists negative traits (lazy, rushes too fast)

_____9. Good assessment skills

_____10. Uses self well

_____11. Asks for help

_____12. Needs to use self better

_____13. Willing to take risk/eager to learn

_____14. Good clinical skills

_____15. Other _____

Respondent #_____ Rater #_____

10. Therapist's Wish of Supervisor Opinion

_____1. Same as #9

_____2. Risk taker/Eager to learn

_____3. Good joining skills

_____4. Experienced

_____5. Needs more experience

_____6. Good theory, well-read

_____7. Lists positive traits (warm, caring)

_____8. Good assessment skills

_____9. Other _____